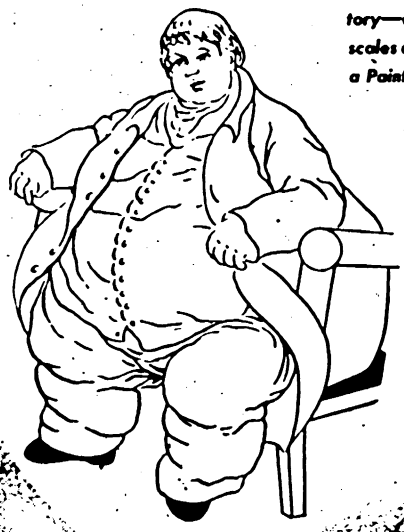

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The Canadian Nurse

VOLUME 48 NUMBER 2

FEBRUARY, 1952

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE *nor of the Canadian Nurses' Association.*

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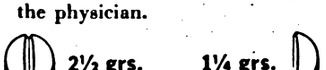

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Between Ourselves

Fifth largest of the Canadian provinces, ***Saskatchewan*** has a population of some 854,000 persons. There are 135 hospitals for the treatment of acute diseases, 3 mental institutions, 3 tuberculosis sanatoria, with a total bed capacity of nearly 10,000. Providing the nursing care for all the patients who occupy these beds, visiting families in the community, supervising the health of school children, and doing the thousand and one things common to our profession are the 2,160 members of the Saskatchewan Registered Nurses' Association. President of this progressive body is **Isabelle Elizabeth Langstaff,** our guest editor this month.

Born and educated in Yorkton, Miss Langstaff is the youngest of three sisters who all became nurses. She graduated from the Regina General Hospital where she worked as admitting officer until she enlisted for service in South Africa and Italy during World War II. She secured her certificate in public health nursing from the McGill School for Graduate Nurses in 1947, completing the work for her degree two years later. Miss Langstaff is health instructor in the Normal School in Saskatoon.

Supplementing the glimpse Miss Langstaff gives us of the developments in Saskatchewan, you will find some additional interesting information in Trends in Nursing.

* * *

Over 100 years ago, Richard Bright of Guy's Hospital, London, recognized that the combination of edema of the face and ankles and albumin in the urine was usually associated with a lesion of the kidneys. **Dr. Robert A. Starr** sketches the details of signs and symptoms, treatment, etc., for us while **D. Margaret Thompson** and **Beatrice Campbell** supply the essential information regarding nursing care. We have no idea why they do not encounter patients with ***acute glomerulonephritis*** in their home visits but the Ottawa Branch of the Victorian Order of Nurses reported themselves out of touch with this condition when we requested an article on the community aspects of care.

We often wonder how nurses and others who read the articles that appear each month react to them. Many of you express your appreciation in notes to us but how many nurses write to the authors? Recently Dr. **H. B. Atlee** wrote us that "there has been quite a response to the article on the ***Maternity Hospital.*** One head of an obstetrical department flew all the way down here (to Halifax) to talk the matter over and seemed quite enthusiastic."

On the other hand, **Gertrude M. Hall,** whose article on the possibilities of ***central schools*** appeared in our *Journal* last October and in *The Canadian Hospital* in November, tells us that her correspondents, many of them nurses, have mentioned only that they read her article in the latter publication. Curious, eh?

* * *

This month you can read in either *The American Journal of Nursing* or this issue the interesting article by **Nettie D. Fidler** on the current and projected ***research programs*** being sponsored by the Canadian Nurses' Association. Many years ago (*The Canadian Nurse,* January, 1946) Bixler and Bixler gave us half a dozen criteria by which the professional status of nursing can be measured. "*A profession constantly enlarges the body of knowledge it uses, and improves its technics of education and service by the use of the scientific method.*" Miss Fidler's account of what is being done and planned indicates clearly the shift in emphasis that is underway.

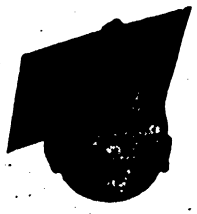
* * *

The Victorian Order of Nurses for Canada had **Ruth W. Hubbard** as their very able speaker at their supervisors' conference last autumn. We are delighted to have the privilege of presenting her address to the wider audience the *Journal's* pages make possible. We hear a great deal about the ***importance of teamwork*** today. Miss Hubbard points out its values, its implications, and the net result in terms of more effective service to the public. It is worth studying.

Middle Age—When a woman will do anything to feel better except give up the thing that's hurting her.

Baby A—2 weeks

Baby B—5½ months



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Edited by **PROFESSOR F. N. HUGHES**

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Description—Each tablet contains: Homatropine Methylbromide 1/24 gr., Phenobarbitone ¼ gr.

Indications—Conditions where a gastrointestinal antispasmodic and central sedative are indicated.

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Administration—1-3 tablespoonfuls (16-48 cc.) daily before meals in single or divided doses.

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Sulfamerazine	0.1 gm.
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[redacted]

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REFERENCES
1. Am. J. Obst. & Gynec., 31:979, 1936. 2. Clin. Med. & Surg., 46:327, 1939. 3. Western J. Surg., Obst., & Gynec., 51:150, 1943. 4. Med. Rec., 155:316, 1942. 5. J. Health & Phys. Ed., 14:154, 1943.

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Indications—To promote healing of peptic ulcer and to relieve symptoms due to gastric hyperacidity, with or without tendency toward pylorospasm.
Administration—Two tablets every 3 hours as necessary for relief.

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Manufacturer—Abbott Laboratories Limited, Montreal.
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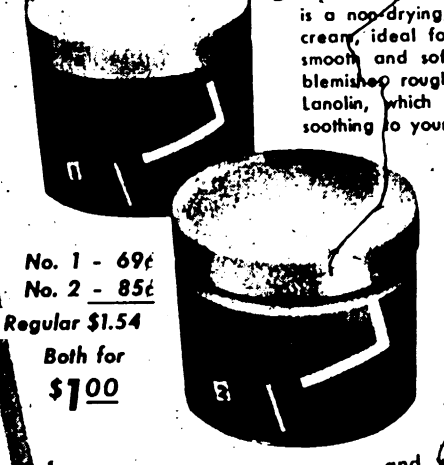

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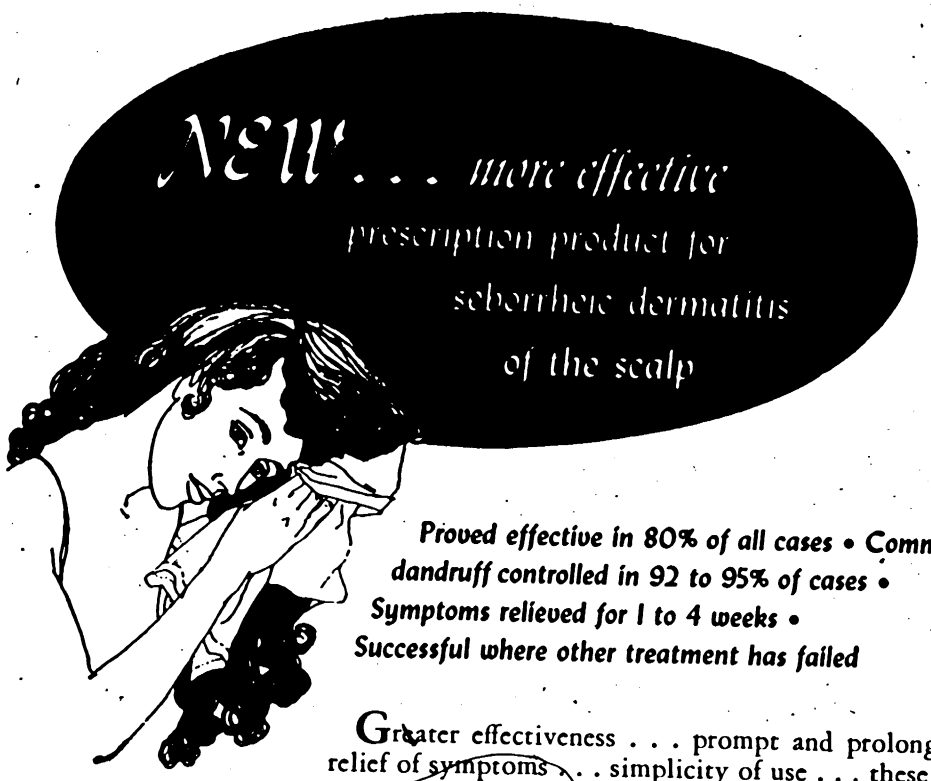

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1. Slinger, W. N., and Hubbard, D. M. (1951), Arch. Dermat. & Syph., 64:41. July.
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The CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME FORTY-EIGHT *NUMBER TWO*

MONTREAL, FEBRUARY, 1952

Our Responsibilities Grow

TODAY WE ARE realizing more and more the need for cooperation in our everyday living. Group effort and teamwork are almost jargon. In the international picture the United Nations is primarily working toward the furtherance of cooperation between nations. Cooperation on an international level can be seen developed to a very high degree in the work of the International Council of Nurses. It shows what can be accomplished when a group meets with a *real* desire to reach an objective.

The desire of the United Nations is for world peace. The desire of the International Council of Nurses is for better nursing education with resultant better nursing care around the world. This goal can and will be accomplished because it is the main interest and desire of nurses throughout the world.

A major step toward our international program in nursing took place in the summer of 1951, when nursing made its first entry on the Agenda of a United Nations body. At this meeting a report of the World Health Organization Expert Committee on Nursing was presented to WHO. The acclaim with which it was received was overwhelming.

Internationally, nationally, and provincially the urgent need for ever-increasing representation for nurses is

ISABELLE E. LANGSTAFF

becoming more apparent if we are to widen our horizons as a profession. On a national level the representation of the Canadian Nurses' Association on the multitudinous committees of the various official and voluntary agencies serves to indicate the recognition which has been attained by nursing in the past quarter century.

On the provincial level, and specifically in Saskatchewan, much has been achieved in gaining representation on various provincial committees and boards. This is due in part to former nursing leaders in the province who, through their vision, laid the foundations. The work of former presidents and members of Council of the S.R.N.A., whose strength and leadership were responsible for establishing these good relationships, is gratefully acknowledged by nurses in the province. It is recognized, however, that much of the credit is due to Miss K. W. Ellis, the former registrar, whose guidance and vision contributed so much to the growth and development of the Saskatchewan Registered Nurses' Association.

Health Surveys have now been completed in the provinces of the Dominion. In Saskatchewan, the provincial nurses' association had representation on both the Health Survey Committee and the sub-Committee on Hospitals—the two committees responsible for undertaking the survey.

With the setting up of a Civil Defence organization the association was asked to send representatives to the Civil Defence Advisory Council in addition to acting on the Health Services Committee and the sub-Committee on Training. At the request of the Civil Defence Health Services Committee, a Nursing Advisory Committee has been established.

The association is watching the step-by-step development of the Civil Defence program. It is gratifying that nursing in this province has had a real place in this planning from its very birth.

Civil Defence is a new development in provincial programs. It but serves as an example of the rapport which our profession has and the part we are able to play in health planning in Saskatchewan. The place given to our profession and the opportunities provided through good relationships with the government, the university, and all official and voluntary agencies are greatly appreciated by the S.R.N.A. However, these relationships are two-way affairs. It is our constant concern that we make a real contribution on our part and pull our weight in the development of not only nursing but of all education and health programs in the province.

ISABELLE E. LANGSTAFF
President
Saskatchewan Registered Nurses' Association

South Africa

At the quarterly meeting of the Public Health Section of the Royal College of Nursing, Miss G. Buttery from South Africa was one of the speakers. She gave a brief report on developments in her country, beginning by stating that it covers 472,494 square miles and has a population of 2½ million Europeans and 10 million non-European peoples. Miss Buttery outlined the development of nursing self-government in South Africa from state registration in 1891 to the formation of the Nursing Council in 1944 which deals with the training and registration of European and non-European nurses. The South African Nursing Association is open to student nurses and membership is compulsory. In addition to basic nurse training, there is a health visitors' training course of nine months organized by the Royal Sanitary Institute and mothercraft training. Miss Buttery mentioned the prevalence of communicable diseases such as typhoid, smallpox, plague, etc.—*Nursing Times*, Nov. 3, 1951.

Acute Glomerulonephritis

ROBERT A. STARRS, M.D., C.M., F.A.C.P., F.R.C.P.(C.)

IN 1827 RICHARD BRIGHT published his first description of the disease which was to bear his name to this day. His classical article is an amazing example of keen clinical observation and shrewd deduction. From the clinical viewpoint little can be added today to what he detailed so long ago. Indeed the more modern biochemical and laboratory discoveries have served merely to confirm his conclusions.

Many pathologists prefer the name Bright's disease to that of glomerulonephritis as the chronic stage of the disease does not present the features of inflammation.

DEFINITION

Christian defines the disease as the result of a diffuse, partly inflammatory and partly degenerative, lesion of the various anatomical constituents of the kidney, which decreases renal function, affects the body as a whole, and causes abnormalities in the urine, of which albuminuria is the most constant.

CLASSIFICATION

The very many different classifications that have been described over the years have greatly confused the understanding of the disease. Some have been based on clinical features, some on pathological differences, others on a combination of both. Christian suggests the following:

1. *Acute Bright's disease* (acute glomerulonephritis).
2. *Subacute Bright's disease* (subacute glomerulonephritis): (a) hemorrhagic, (b) with renal edema (the nephrotic syndrome).
3. *Chronic Bright's disease* (chronic glomerulonephritis): (a) without edema, (b) with edema (the nephrotic syndrome).

Boyd prefers to refer to these three types as the first, second, and third stages of glomerulonephritis. This has the merit of emphasizing the fact that they are not different diseases but merely progressive stages of the same disorder.

As Osler states, acute Bright's disease is the first stage of a process which may pass on to subacute and chronic stages. In some cases the condition may clear and the patient recover completely, or the early stages may be latent and overlooked so that the disease is recognized first in a subacute, chronic, or even terminal stage. The acute process may apparently clear but in fact only becomes latent, to show at some later date that, slowly and insidiously, the renal disease has been progressing to a chronic stage.

ANATOMY AND PHYSIOLOGY

Some knowledge of the anatomy and physiology of the kidney is essential to an understanding of the symptomatology, pathology, and course of the disease.

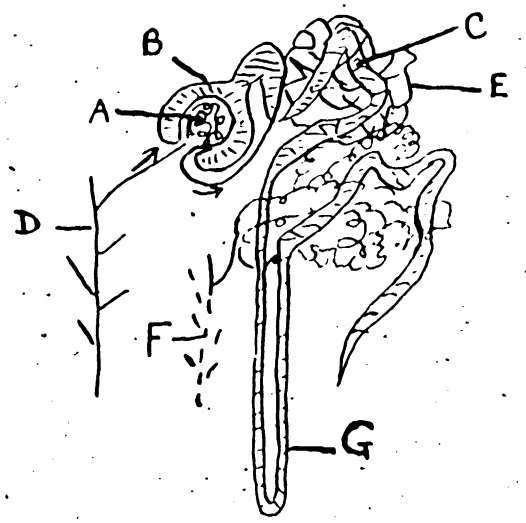
The minute structure of the kidney shows a plan that is familiar—epithelial surfaces in contact with the capillary network. This arrangement is evident in each *nephron*, which constitutes the structural unit of the kidney. The number of nephrons has been calculated as about two million which confers upon the kidney a large reserve power.

The nephron consists of a renal corpuscle, the *glomerulus*, which, with its corresponding tubule, forms one structural and functional unit. Injury to a glomerulus is reflected in changes in its tubule.

The glomerulus consists of several loops of a capillary vessel which is lined by a loose layer of endothelial cells and covered on its outer surface by a thin epithelium, the capsular space and the surrounding Bowman's

Dr. Starrs is associated with the Department of Medicine, Ottawa Civic Hospital.

capsule, also lined by a thin layer of epithelial cells. The essential function of the glomerulus is to act as a selective filter of the blood which courses through its capillary loops. On the other hand, the main role of the tubule, aside from transporting the urine to the renal pelvis, is one of reabsorption. Normally the glomeruli filter off about 100 litres of water in 24 hours but the tubules reabsorb all but about 1.5 litres. The glomeruli excrete considerable amounts of glucose but normally all of this is reabsorbed. Urea, however, being a waste product, is but little reabsorbed. The tubules reabsorb sodium and other electrolytes in amounts sufficient to maintain the electrolytic balance of the blood. The normal glomeruli do not allow the passage of the large protein molecules, hence albuminuria is ordinarily the surest indication of glomerular damage. Over a 24-hour period rather large numbers of erythrocytes and smaller numbers of leukocytes are excreted normally but not in sufficient numbers to be significant findings on ordinary microscopic examination of the urinary sediment.



One nephron showing: A. Glomerulus. B. Bowman's capsule. C. Convoluted tubule. D. Interlobular artery. E. Secondary capillary network. F. Interlobular vein. G. Henle's loop.

Etiology

There is often no obvious causative factor but glomerulonephritis usually follows infectious diseases, such as scarlet fever, or acute infections of the upper respiratory tract, such as tonsillitis and common colds. Such preliminary lesions are commonly the result of infection by hemolytic streptococci. Exposure to cold and dampness predispose, probably in the main, through resulting respiratory tract infection.

There is usually a latent interval between the acute infection and the manifestations of nephritis. It commonly appears in the third week of scarlet fever. This feature has led many to conclude that the renal lesion is the result of a sensitization to the streptococci, especially as the bacteria themselves are not found in the kidney.

However, most authorities today believe that the renal damage is a direct result of endotoxins or exotoxins produced by the streptococci.

Pathology

In acute Bright's disease the dominant lesion is glomerular, the tubular lesion being secondary and less significant. Boyd stresses that there is a blockage of the capillaries of the glomerular tuft, due partly to swelling and proliferation of the endothelial cells within the capillary and partly to the formation of a hyaline material. The affected glomeruli, therefore, are bloodless.

The second stage of glomerulonephritis (subacute) is one of degeneration and proliferation with the tubules often being markedly involved, just as the third stage (chronic) is one of scar formation, atrophy, and often actual disappearance of many glomeruli and their associated tubules.

Marked degeneration and even necrosis of tubular epithelium may heal by regeneration but the glomeruli have much less power of restitution and no power of regeneration. If acute nephritis heals completely, then the glomerular lesions must have been minor, probably with many glomeruli not injured.

The earliest lesion of the glomerulus is a slight thickening and hyaline change in the basement membrane of the capillary loops. This may increase so as partly to obstruct the lumen of the capillary tuft but usually evidence of proliferation of the endothelial cells within the capillary and the epithelial cells covering the tufts and lining Bowman's capsule now appears, and this may choke the capillary loops, fill the capsular space or form peculiar localized masses of epithelial cells over a portion of Bowman's capsule. This latter lesion is known as the epithelial crescent and is pathognomonic of glomerulonephritis.

Polymorphonuclear leukocytes may gather in the tufts or escape into the capsular spaces and so enter the tubules. Red blood cells more often do the same and albumin invariably does so. Thus albuminuria and hematuria indicate lesions of the glomeruli. The cells in the epithelial casts are derived from the tubules but those in the leukocytic and blood casts come from the glomeruli.

The epithelium of the tubules shows degenerative changes, cloudy swelling, granular and hyaline transformation, fat droplets and actual necrosis but these changes are more pronounced in the second stage. In the lumen of the tubules are granular detritus, desquamated epithelial cells, red blood cells, leukocytes, and casts of all sorts.

The gross appearance of the kidney is one of moderate to considerable swelling so that its weight is increased. The color may vary from red to pale yellowish-gray with or without punctate hemorrhages. The cut surface slightly everts and shows the same color variation as the exterior of the organ. Glomeruli may be visible as minute red or gray foci. Rarely the cut surface drips blood but more often the cortex is pale while the pyramids look congested.

Symptoms

In the typical case of acute Bright's disease the onset is abrupt but the symptoms may not be particularly distressing. The patient may experience some of the following complaints:

Malaise, puffiness about the eyes and face, moderate swelling of the lower legs, dull discomfort in the lumbar areas, slight fever, chilly sensations but rarely a chill, headache, epistaxis, anorexia, nausea or vomiting. In children convulsions may occur. Pallor of the skin is usual but actual anemia is not as characteristic as it is in the chronic stage.

Oliguria, a marked decrease in the output of urine, is commonly noted immediately and occasionally there may be complete anuria. The specimen is usually dark, cloudy or smoky, and not infrequently grossly hemorrhagic. The specific gravity is above normal, unlike the findings in the chronic stage. Other urinary changes include the invariable presence of large amounts of albumin, red blood cells, leukocytes, casts. There is a low urea content in the urine with a corresponding retention in the blood. A slight leukocytosis is common.

The blood pressure typically is moderately elevated but Boyd states that this occurs in only about one-third of the acute cases and he considers it a beneficent compensatory reaction to aid in glomerular filtration. Persistence of hypertension, however, is definite evidence that the acute process has not healed.

Hemorrhagic retinopathy is rare in the acute case, again in contrast with the chronic stage.

The above symptoms and findings occur in different combinations and degrees in individual patients so that the clinical picture exhibits many variations. Many of the mildest cases probably escape detection in the acute phase and constitute the unrecognized beginnings of what in later years will be diagnosed in the chronic or even terminal stage. When microscopic hematuria persists for months it is evidence that the disease has progressed to the subacute or second stage.

In explaining the true nephritic edema of the acute stage it has been stressed by various authorities that the cause is extra-renal. Fahr suggests a change in the capillaries of the subcutaneous tissue which makes them

more permeable. Salt retention is not due to failure of the kidney to excrete sodium. Rennie considers the edema due to a combination of a rise in blood pressure and a fall in the plasma osmotic pressure, which he attributes to defective synthesis of the proteins by the liver as well as to the loss of protein in the urine.

However, a decrease in the serum albumin is not so common in acute glomerulonephritis as it is in the nephrotic phase of either the second or third stages of the disease. Here the extensive generalized edema is undoubtedly due to the great fall in the osmotic pressure of the blood caused by the extreme proteinuria.

Most pathologists no longer accept Epstein's view that so-called lipoid nephrosis is a separete entity but believe that there is slight glomerular damage, though not sufficient to block the glomeruli as in the typical form of glomerulonephritis. Thus albumin is free to pass through the glomeruli in large amounts. The tubules undergo a marked degeneration, characterized by lipoid deposits. In this type of case the blood pressure is not elevated, the edema is very extensive, the urine is loaded with albumin but seldom contains casts or red blood cells, the blood cholesterol level is high, the blood N.P.N. is not elevated but commonly the B.M.R. is below normal. The consensus today is that it is a form of glomerulonephritis.

Diagnosis

In the typical case diagnosis presents little difficulty. However, where symptoms and signs are minimal prolonged investigation may be necessary. Acute exacerbations of the chronic disease may be mistaken for attacks of acute nephritis. The history, the condition of the heart and vessels, the eye grounds, and the blood pressure are important points in recognizing the existence of previous nephritis.

Prognosis

As Christian states, in a case of acute Bright's disease there are four possibilities: (1) complete recovery; (2) death during the acute stage; (3) steady progression into the chronic disease; and (4) apparent recovery, a latent period, which is often long, before the emergence of the final progressive chronic stage.

Bell estimates that 5 to 10 per cent of cases die in the acute stage and that complete recovery occurs in about 50 per cent. Fatal cases usually die of uremia or, less commonly, congestive heart failure. Intercurrent infection, such as pneumonia, accounts for a smaller number. Observation over a period of years may be necessary to determine the eventual prognosis.

The method of Addis of making repeated accurate counts of red blood cells and casts in the 24-hour specimen of urine probably gives the best data on which to estimate prognosis and to recognize latency. Unfortunately, it is time-consuming and somewhat difficult to carry out. Therefore it has not gained widespread acceptance.

Progressive rise in blood pressure and persistent microscopic hematuria are evidences of chronic and probably progressive glomerular damage.

The recurrence of acute exacerbations following infections, or even apart from the latter, may ruin any prophecy that has been suggested.

Treatment

The treatment of acute glomerulonephritis has left much to be desired over the years since Bright first described the disease. No unanimity of opinion has prevailed except over the one point of the necessity of prolonged bed rest. There is no doubt that this represents the most effective therapeutic agent. It is probably wise to keep the patient in bed during the first couple of months or as long as the urine contains red blood cells, considerable albumin, and casts other than the hyaline variety.

Most authorities feel that there is little place for drugs beyond symptomatic needs. If any infectious process is still present, antibiotics may be used but they are of no value for the nephritis itself. Experience has revealed that cathartics, diuretics,

hematinics, and cardiac stimulants have offered nothing. The use of hot applications and cupping over the lumbar areas has lost favor. Digitalis therapy is advisable when evidence of congestive heart failure appears. The use of intravenous magnesium sulphate early in the course of the disease has had its adherents but did not gain wide acceptance. As Christian remarks, watchful waiting rather than aggressive warfare should be the keynote in managing the patient with acute Bright's disease.

Marked differences of opinion still exist concerning the choice of diet and the amount of fluid to administer. Some have favored complete abstinence from food and fluid for the first several days. Many still feel that Karrell's method of offering only 800 cc. of milk daily for about the first week is advisable. However, most clinicians today favor a simple diet moderately restricted in protein and low in sodium while the symptoms are marked. Then this is followed by a more adequate diet, restricting protein only while the blood N.P.N. is elevated. Fluid is allowed in amounts from 1,000 to 1,500 cc. Addis, however, disagrees with those who allow protein approaching normal intake. He feels that protein should be sharply restricted while the urine contains many red blood cells indicative of active glomerular damage.

Edema rarely is disturbing in acute Bright's disease and seldom requires special therapy. This is in contrast with the situation in the nephrotic syndrome where the treatment of edema must be energetic. In the latter a very high protein diet, restriction of sodium, the use of blood transfusions and plasma infusions or, better still, salt-free serum albumin intravenously where it is available, judicious use of mercurial diuretics and mechanical measures for the removal of edema fluid all serve a valuable purpose.

Nursing Care in Nephritis

Beatrice Campbell

Mr. Kirk was in excellent health until 1944, when he developed swelling of the face and neck, puffiness beneath the eyes, shortness of breath on exertion, nocturnal dyspnea, and a gain in weight from 165 lb. to 180 lb. He was always tired. On consulting his doctor, urinalysis revealed albumin. The diagnosis of nephritis was made and a treatment of milk diet and a two-week period of observation in the hospital was advised.

During this period of hospitalization, Mr. Kirk was kept at rest in bed and the necessity of avoiding over-exertion and upper respiratory infections was emphasized.

When the patient became edema-free and the urine was free from albumin, casts and red blood cells, the doctor allowed him to sit up, then to get out of bed dressed warmly and thenceforth to become increasingly active. The nurse prepared him for discharge, teaching him to resume normal activities gradually, and to avoid fatigue.

After two weeks his condition was greatly improved with return of strength and loss of swelling. He went home on a low protein diet with instructions to return to the doctor at regular intervals each year for urine examination and general check-up.

In the late fall of 1950, he consulted his doctor again for dizzy spells, extreme fatigue and palpitation on exertion. He was advised to rest but became steadily weaker, developed frontal headache, pain down the back of the neck, and general malaise. At this time he was readmitted to hospital.

On admission he was notably pale and puffy about the eyes but not complaining of any discomfort. He was

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cheerful. The following day an N.P.N., blood creatinine and complete blood count, and routine urinalysis were done.

The N.P.N. was 86.8 (normal 25-35 mgm. per 100 cc. blood), which indicated that the non-protein nitrogenous wastes, urea, uric acid, and creatinine were accumulating in the blood.

The blood creatinine was 9 (normal 1-2 mgm.%). This test is done chiefly for prognosis, as the creatinine level rises only when kidney impairment is severe, and a level above 5 indicates that chances for recovery are slight.

Phenolsulfonephthalein and Mosenthal tests indicated damage to both tubules and glomeruli.

Routine urinalysis revealed a specific gravity of 1.010, a plus 2 albumin, many red blood cells and a few white cells.

Both the red blood count and hemoglobin were low, with values of 3,630,000/c.mm. and 69%, which contributed to his fatigue.

Mr. Kirk was put on complete bed rest because body activity increases the amount of waste products that have to be eliminated by the kidneys.

Care was taken in placing Mr. Kirk in the ward where he would not be exposed to chilling or infection from patients with respiratory diseases. No nurse with any signs of a cold was assigned to his care.

As Mr. Kirk perspired considerably a daily bath was necessary, with water sufficiently warm to bring a glow to the skin and stimulate circulation and elimination. A flannelette drawsheet was used as it was more absorbent and lessened the danger of chilling. It was necessary to make sure he was turned frequently and special attention was given to all pressure areas to prevent decubitus ulcers.

To check upon the degree of his edema, Mr. Kirk was weighed daily. He was placed on a restricted fluid and salt-free diet. His intake and output were measured. The reasons for these restrictions were explained to Mr. Kirk and his thirst was alleviated by frequent rinsing of the mouth with ice water. Special mouth care was given before and after meals.

As Mr. Kirk's disease progressed, he became more restless, complaining of blurred vision and pruritus. To ease the irritation, sodium bicarbonate was added to the bath water and calamine lotion with 1% phenol was used.

Shortly after this he developed slurring of speech and marked weakness in his right arm, which necessitated assistance with feeding. Later muscular twitchings and dyspnea were noticed. Mr. Kirk gradually went into uremic coma which terminated in death.

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Government Gives Financial Aid

The excellent two-year program for the training of student nurses conducted by the Metropolitan School of Nursing received official recognition recently when the Ontario Government, through Dr. J. T. Phair, Deputy Minister of Health, notified Miss N. D. Fidler, director of the School, that a professional training grant would be made. National Office, C.N.A., has learned that the grant, for the period December 1, 1951, to March 31, 1952, inclusive, amounts to $14,319.51.

Financial assistance is necessary to enable the School to complete the training of the fourth class which will be graduated next September. The Canadian Nurses' Association is most grateful for this timely help from the government of Ontario.

Nursing Care in Bright's Disease

D. MARGARET THOMPSON

KIDNEY DISEASE ranks among the top ten causes of death in Canada. Therefore, a study of this condition is both interesting and essential since it is met with so frequently in medical nursing. Mr. Dennis was a very good subject for study. His illness terminated in death but this, too, was typical of this illness. The slow downward decline is well illustrated by this study.

Because of his long stay in hospital, a great deal of material was recorded about him and also many tests and examinations were made. It is impossible to include them all in a study of this kind. Therefore, it will take a more general form but will show the essentials of care given.

The function of the kidneys is to eliminate the nitrogenous wastes of metabolism and to aid in keeping the composition of the blood constant. The glomeruli act as filters. Water and dissolved substances pass through the capillaries into the capsule of the glomeruli. The blood pressure furnishes the force for filtration. With an increase in blood pressure the filtrate is increased and vice versa. The tubules of the kidneys carry out further filtration, selective absorption and concentration of the urine, as this waste material is called.

Any pathological change which decreases blood flow through the glomeruli will decrease glomerular filtration. Mr. Dennis was found to have arteriosclerotic disease of the blood vessels as well as damaged and obliterated nephrons. This caused a decrease in the blood supply to the glomeruli. Thus the essential amounts of wastes were not removed from the blood. The whole chemical balance of the body was disturbed and Mr. Dennis progressed to uremia, indicated by the presence of excessive wastes in the blood. Death resulted because the collection of wastes was so great that the cells of the body could not function normally.

Miss Thompson graduated from the Vancouver General Hospital last year.

SOCIAL HISTORY

Mr. Dennis was a Canadian, 52 years of age. He had a wife and no living children. He was a partner in a trucking firm in his home town. His financial status was very good. He had a prospering business and lacked nothing which money could buy. There were no racial, family, or mental problems affecting his health, except perhaps that he and his wife enjoyed a very busy social life which entailed late nights and moderate drinking. Having once become accustomed to such activities, they found it difficult to settle down to a slower pace and quieter life and so continued their social rounds.

A tall man, Mr. Dennis weighed 181 pounds on admission to hospital. This was nine pounds overweight for his height and age. His work was essentially sedentary but it did entail some physical exertion. Latterly, before admission to hospital, he had been suffering "bilious" attacks. Normally his appetite was good and the diet of the family was, perhaps, more than adequate. He was edentulous but had a good set of upper and lower dentures.

With regard to sleep and rest, Mr. Dennis always kept late hours. He had many friends and visited about a great deal, going to shows and parties. As he did not have to arrive at work at any set hour, he made up his seven to eight hours of sleep by resting later in the morning. His job afforded him a normal amount of exercise. He was fond of sporting events—horse racing, trotting meets, ball games—but only as a spectator. However, he did maintain a garden

so this afforded some outdoor activity

History of Illness

When 10 or 11 years old, Mr. Dennis remembered having stayed home from school for one year. The actual illness was unknown but he thought it was somewhat similar to the present one. He had scarlet fever when 12 years old, typhoid fever the following year, was gassed in World War I and also had influenza while in France. He had complained of tiredness and headaches for the past year. He had also had frequency and nocturia (averaging twice per night). There had been some pain over the kidney regions for a considerable time.

Mr. Dennis exhibited some edema of the face which was particularly noticeable around the eyes. His general condition was moderately good. He was quite intelligent and was most cooperative. Even as he became more and more nauseated, he made a real effort to eat what was served to him. Any requests he made regarding food would be fulfilled and he tried desperately to eat and retain this food. However, in the very late stages of his illness, his diet became quite a problem as he was continually nauseated and vomiting and was often confused.

The physical examination of Mr. Dennis showed him to be essentially normal. His pupils reacted equally to light. Examination of the chest showed it to be clear. The heart rate was regular and normal as were the heart sounds. His blood pressure was 180/100—considerably above the normal for his age (130/100). His abdomen was found to be essentially negative except for a right, indirect, reducible, inguinal hernia. The tentative diagnosis was: nephritis with impending uremia.

The immediate treatments ordered were: rest in bed, sedation to ease the pain in the kidney area and induce rest.

Laboratory Tests

Laboratory work was essential to confirm the diagnosis and to watch the progress of the patient's illness. On admission, hemoglobin was 54% with 2,700,000 red blood cells and a color index of 1.0. The white blood cell count was 8,100. The N.P.N. was 92 mgm.% (normal 25-35 mgm.%). Mr. Dennis had 15 blood transfusions, altogether, with his hemoglobin at one point rising to 85%. The N.P.N. showed a steady rise from 92 mgm.% to 272 mgm.%, shortly before his death.

The specific gravity of the urine was usually in the neighborhood of 1.012 (normal 1.001 to 1.026) though it ranged down from 1.020 to as low as 1.001. Every urinalysis showed at least plus 4 albumin and plus 2, 3, or 4 red cells. White cells were present in many of the tests and toward the end both hyaline and granular casts were occasionally present.

Plasma chlorides were generally low starting at 432 mgm.%. At one point they rose to 520 mgm.% in the latter weeks of his illness.

Nursing Care

The chief aspects of nursing revolved around supportive care and making the patient as comfortable as possible. Mr. Dennis was confined to bed for his entire illness. At first he was rather restless and anxious to be up but later he became so weak and so easily tired that bed was the only place where he was comfortable. One attempt was made to get him up into a chair but as this tired him so much and caused severe vomiting it was not repeated. While in bed it was necessary to guard against chills and upper respiratory infections. Draughts and dampness had to be avoided. Penicillin and streptomycin were also used to prevent any infection as the body resistance was very low.

Extreme cleanliness was of great importance. He was given a full bath every day followed by an alcohol rub. This bath was essential as there was a high concentration of waste products in the perspiration excreted onto the skin surfaces. Special care to back and bony prominences was given frequently both day and night. All dur-

ing his long stay in hospital Mr. Dennis did not once develop a sign of a pressure sore. Pruritis of the skin was a very annoying factor in his illness. He would scratch interminably if left alone. We found that applications of calamine lotion were very beneficial in relieving this itchiness.

The fluid intake and output (through urine and emesis) were carefully measured and recorded. When vomiting persisted and Mr. Dennis was unable to retain fluids, intravenous therapy was instituted to keep the fluid intake up to the desired level.

Various means of checking the vomiting were attempted. None was very successful. At first ginger ale was given shortly before meals. This worked well for a time. Then it was decided to give a dry cracker or bread before the meal. This was not satisfactory. Finally, the solid and fluid parts of the meal were given separately, as far as possible. This was helpful for a time but when uremia developed there was little we could do to prevent his constant vomiting.

One thing that bothered Mr. Dennis considerably was his failing vision. He would reach for things and be unable to find them. Gradually he became unable to read the cards and letters sent to him. A great deal of tact was necessary to help him through this very disturbing phase. Apparently casual assistance was essential. He did not want to feel useless and, therefore, we had to be very careful how we helped him. Mrs. Dennis was very helpful. She came to the hospital for a good part of each day and did many things for him. She attended to his mail and helped him with his meals.

Crib-sides were applied to the bed as his vision failed and Mr. Dennis became more and more restless. He had periods of extreme confusion and appeared almost comatose at times. It was now necessary to give special care to his mouth, over and above the regular mouth washes. Glycerin and lemon juice proved to be a very effective preparation.

The danger of convulsions became more and more imminent as the illness progressed. For this reason Mr. Dennis was watched very carefully for any signs of spasm or muscular twitchings. A mouth gag was kept in his room at all times, as was a syringe and a vial of 50% magnesium sulphate. This was to be given if a convulsion occurred in order to reduce the edema of the brain.

Hemorrhages from the mouth and nose began in the last few weeks of his life. There was little to be done for these except to keep the areas as clean as possible and to prevent digital irritation by the patient. One week before his death Mr. Dennis developed infected areas on his nose, cheek, and hand. They appeared red and inflamed, almost like developing boils. To treat these, hot compresses were applied to the face, and the hand was placed in a sterile bath. This was done every hour during the day and every two hours at night. There was a little pus-like drainage from these areas and treatment of hot applications was continued. However, they never entirely cleared up even with the aid of antibiotics.

The last few days Mr. Dennis suffered several convulsions and medical treatment was instituted. This consisted of intravenous injections of magnesium sulphate and digifortis. However he did not entirely recover consciousness. His speech had gradually become slurred. Eventually it became an unintelligible mutter.

Special nurses were called in at this time and within a few days Mr. Dennis passed away in uremic coma.

Diet

On admission Mr. Dennis was placed on a salt-free, nephritic diet and was maintained on this throughout. The object of this diet is to maintain the body in the best possible condition and so prolong life on the highest possible level. The diet was ample for maintaining normal body weight. The protein was high (120 grams) to replace that lost through gross albuminuria. Sources of sodium were restricted to prevent edema as it is sodium retention which holds the water in the tissues. Water was not restricted as it is necessary to flush

the toxins from the body. The vitamin and mineral-rich foods were stressed as they were essential to maintain normal body functions.

Fats were limited to the more readily digestible forms. No rich foods were served as they were hard to digest and often induced further vomiting. When the N.P.N. became very high the food proteins were somewhat restricted but this was not continued for too long a period as it was felt that Mr. Dennis needed available protein for body repairs.

Conclusion

The main problems in this case were dietary because of the persistent vomiting. The attempts at solving these have been mentioned.

The most important observation was the laboratory reports. They indicated the actual condition of the patient.

This study was particularly valuable because of the information I gained while doing research reading on the condition. I now have a much better understanding of the kidney diseases. To actually apply theoretical knowledge to a practical situation is very beneficial. I enjoyed making this study because I knew the patient so well and came to understand his illness.

In the Good Old Days

(*The Canadian Nurse* — February 1912)

"Tuberculosis is perhaps the most dreaded of all diseases by the nursing profession. A few years ago diphtheria and smallpox were perhaps more to be feared, but we have now an antitoxin for the former and we vaccinate for smallpox; for tuberculosis there is only fear.

"Tuberculosis thrives in some animals, especially the cow. It has been proven that a man with consumption can infect a cow and also that tuberculosis in cattle may cause the disease in human beings.

"It is possible, but improbable, that the disease is transmitted directly to the unborn babe. It may occur through the ovum or directly through the bloodstream and placenta. It seems more reasonable, however, that the babe is infected after birth by the father or mother."

* * *

"The apprenticeship method in nursing education has many weaknesses. It is unjust and undemocratic in its scope, unscientific and antiquated in its educational methods, and fundamentally unsound from the financial and economic point of view. It is wasteful of time, of human energy, and in many cases of human life. It tends to restrict initiative and individual advancement, hampering progress.

"The objection to the apprenticeship method of training is not that it teaches through practice, but that it teaches the technique of practice without the reasons, that it emphasizes the muscle side—the hand side—and neglects the thought side which is fundamental to true efficiency."

* * *

"Following the graduation exercises, each nurse was presented with a suitcase in token of appreciation of her two years of earnest, faithful work. These are useful souvenirs of the hospital."

* * *

"The Graduate Nurses' Association of the Thunder Bay District has decided to have the names of graduates inserted in the telephone directory under a classified heading."

Seton Hall University, South Orange, N.J., instituted a new program in the fall of 1951. Qualified graduates of diploma courses in nursing will be admitted to the university for the revised general nursing curriculum leading to the B.S. degree. This program replaces the special curricula in nursing education and public health nursing which will be terminated when students now enrolled complete their course.

A maximum of 60 semester hours is granted for the basic program on the basis of the applicant's achievement and professional records.—*Hospital Progress*, Oct. 1951.

Working Together for Public Health

Ruth W. Hubbard

In electing to discuss teamwork, I was influenced by my own experience and observation. Fifty or more years ago a speaker might have been moved to talk in a more pioneering spirit—warning you of untried fields, of the adventure of working alone, of the courage needed to persuade the doctor and his patient—or even the community—of the values of a visiting nurse. Happily that theme is no longer appropriate. In its place we have a new era of adventure—the adventure of working together for public health.

When the Fourth World Health Assembly met in May, 1951, in Geneva, 76 nations were counted upon its rolls. This powerful evidence of teamwork for world health is one of the most encouraging facts in the world today. Your own distinguished citizen, its director (Dr. Chisholm), is no small factor in its successful growth. But it is true that even Dr. Chisholm could make small progress in WHO without the support of all the peoples of the 76 member nations who are united in the belief that good health is a basic right for every human being and that the protection of that health is a common concern of all mankind. It can be construed as selfish concern since another's sickness may endanger us, whether the ill person be a neighbor close at hand or in a country halfway round the globe. But it is deeper than that. It rests upon our belief in the dignity and integrity of the individual. To enable each individual under our care to achieve the maximum of his potential good health so that he may make the richest possible contribution to his generation is a goal which can unite 76 and more nations—even in a war-torn world. It is, in fact, the hope of that world.

Miss Hubbard is general director of the Visiting Nursing Association, Philadelphia.

There are many kinds of teams and of teamwork. In the field of public health they change with programs and programs are altered as old problems are met or new needs appear. Two generations ago environmental sanitation preoccupied health workers while the hazards of motherhood and the diseases of early life took heavy toll in death. Today medical scientific advance and enlightened public health practice have brought these problems under control so that we are free to turn an increasing part of our effort toward the prevention, early discovery, and alleviation of the diseases of middle and later life.

As yet, medical science offers us but an incomplete chart for the prevention of all these difficulties. The guides to early discovery and control increase daily. As public health nurses we have been privileged to be part of an ever-increasing army of workers, responsible for teaching people how to prevent these illnesses or to meet them with the new tools of medical science. Ours is both a thrilling and a staggering responsibility.

Throughout our history we have been on the doctor-patient-family team. As nursing itself has matured we have come to recognize ourselves as a professional team, working together from hospitals, institutions, schools, industries, and homes. In public health agencies (especially in those of voluntary character) we have valued our teamship with those representatives of the community who sponsor our work. This is a very vital relationship. Today a fourth team is appearing, sometimes called the multi-discipline or healing arts team. Each of these four has meaning for us as public health nurses. If we are part of a team, we must demonstrate that we can work successfully, not only with each other but with persons of different groups—totally different professions. To be a member of a

team means that we can accept a common goal with others and take our appropriate place in a group larger than our own, to work for that common goal.

We do truly accept the goal of national, provincial, community, and individual health. We honestly realize that we alone cannot achieve that goal and we believe that the others who work for that goal need and want our participation.

To be part of a team means that one must be extremely well prepared in his own field; that he must see himself in relation to the contribution of others; that he must sense constantly the changing needs of the individuals whom he and the group are serving; that he must accept the corresponding changes in his contribution and the contributions of the other team members to those needs; that he must have the courage to say what he can do and why he feels that he can do one thing better than another; that he must have the grace to give up what he likes to do if another can do it better. It means, further, that he must learn to do things which do not come too easily if they can best be done by him for the good of all. It means the will to pull with others and the integrity to withdraw from those parts of an undertaking which are not his. It means the enduring belief that together we can do things which no one of us individually could do alone and that the *togetherness* makes possible a concept of the job which is greater than the sum of the individual parts.

This may seem to you remote from the job that you are doing each day but actually each of us is already a member of a team. It functions well or ill depending on the success with which the team has consciously accepted its teamship.

I firmly believe that each patient whom we serve is aware of our teamship, knows when we are working in accord and senses, somehow, when we are not. Those of us, who are privileged to be in situations where the teamship is well understood, value that sense of oneness with the others above all the other aspects of our working day.

The team concept readily fires the imagination but good teamwork is not always easily achieved. There are at least two difficulties that you doubtless have experienced—time and change. It was Rudyard Kipling who stated succinctly that "he travels the fastest who travels alone." He certainly was right for anyone who has tried to keep in close touch with three or ten members of a group working on a health project or caring for a patient knows how much time must be devoted to conferences, telephone calls, and reports. One has to be thoroughly convinced of the value of the group effort to be willing to maintain contact. This is especially true if the team members are located in scattered places. It is an experience fraught with the difficulties of reaching people at inconvenient hours, being patient under delays, and maintaining perseverance in the effort. It does take time. The convinced team can reduce the time element somewhat by good procedure techniques and that is essential for sustained performance. The question really is—does the outcome justify the time and effort?

The second difficulty, change, we are perhaps prone to approach subjectively. We have been close to a particular patient or project. We are deeply interested and have our own ideas as to the best plan to follow. True, we may need the help of others in achieving the desired goal but we anticipate their full support as soon as they know what is wanted. In real teamwork, however, this is the very point at which changes occur. One or more members of the group offer suggestions from their experience and knowledge which call for alteration in "our" plan. Frequently we see advantage in the proposal and accept readily. But sometimes we find ourselves unconvinced, even sorry to have created the opportunity to receive suggestions. "We have let ourselves in for it" as the saying goes. At such moments we need to ask ourselves frankly—what are we trying

to do on this team and for whom?

It is obviously oversimplification to cite but two difficulties in teamwork and to discuss them so briefly. I do so because they are difficulties of which we as nurses are especially aware. They are also matters which we can influence to some degree. An actual experience may serve to illustrate how we as public health nurses can contribute to effective teamwork on behalf of our patients when we subscribe wholeheartedly to the goal. In the first instance it took time to assure uninterrupted care for a sick child. The seven telephone calls a public health nurse made one busy Saturday morning consumed over an hour and involved the doctor, the clinic nurse, the physical therapist, and the child's father, but they did succeed in relieving anxiety and restoring treatment in one household for a little girl who had infantile paralysis.

To be available to receive such calls, to know where and how to find the answers to questions asked and to be able to interpret those answers to an anxious parent are all part of teamwork in treatment. The time and work involved may tend to discourage their use. Yet this aspect of any health conservation program is emphasized because our experience shows so clearly that the time spent in careful review of a situation, the design of a plan for action, and the provision for team follow-up pays dividends. Some of these may be identified as security in the patient's family, absence of confusion about doctor's orders, continuity in care, reduction of the patient's anxiety or complications, and earlier recovery.

Finally, then, let us look at some of the rewards of teamwork for our individual patients, for the public health, and for ourselves.

For our patient—teamwork can mean effective, understanding continuity of treatment and nursing care, although he leaves the hospital, goes home for a time and may later enter a nursing home or a special hospital. It may, in fact, mean that he can leave the hospital while still in need of skilled nursing care and receive it at home. It can mean appropriate, effective instruction and supervision for the family, whose school-age child is recovering from rheumatic fever, because of the close relationship between the children's heart hospital, the convalescent hospital, the public health nurse, the school nurse, the physician, the case worker, and the visiting teacher. It assures the wage earner release from anxiety during illness because industry, hospital, family physician, public health nurse, case worker, industrial nurse, and rehabilitation workers combine to assist him meet his joint problems of illness and responsibility for others—combine in fact not to tell him what he must do but to help him solve these problems in the way that is best for him and his family.

For the public health—teamwork can mean prevention of much illness by education and health supervision, based on the translation of scientific knowledge into practice. The gap between our knowledge and our practice can be immeasurably reduced if all of us in the healing arts professions really work together with those in the educational and welfare fields and with the families.

I emphasize the families because I believe to work *with* them is the highest essence of the teamwork. It is far beyond working *for* a family. It can not only discover disease early by multiphasic examinations but can assure treatment to control the disease and appropriate supervision to avert recurrences.

It is my conviction that good teamwork can be an important factor in the development of both public and private support of the public health programs. The representatives of the community on our teams can both help us to plan wisely and enlist public opinion on behalf of sound, well administered programs.

So we come to *ourselves and our rewards* as teamworkers. What are we trying to do on this team and for whom? Our very name supplies the answer. We have chosen to be public health nurses so that our part in the

work of the world can be to care for, to nurture, to build up the health of that vast body of people we call the public. The great majority of us work directly with individual patients and their families, giving nursing care, teaching, encouraging, supervising. Because of these close and valued associations we know that many skills, disciplines other than our own, are needed to release our families from the bondage of illness and ignorance—to free them to live richly and fully in health. We know how often interruptions in care can delay recovery, how frequently misunderstanding of medical counsel can result in confusion, how seriously unrelieved anxiety can diminish cooperation and dark despair can paralyze effort. Just as our experience with sick human beings in many places has taught us these things so, too, we have learned that shared troubles are truly solved in the sharing, that patients want to be well and independent, that two or five heads are often better than one when it comes to making family health plans, and that the outcomes of constructive, devoted teamwork can be an achievement beyond the reach of any of us working independently. Our goal is always to help each patient to reach and maintain his best possible health. We are richly rewarded each time that we see this happen. We see it more often where a team works for the health of the public. We see better results than we dared to anticipate. When this happens we are satisfied beyond peradventure. It is enough.

Nursing Research in Canada

NETTIE D. FIDLER, B.A.

HISTORY

FROM THE BEGINNING of the century there has been recognition of the rapidly changing character of nursing and the need for adjustment to this change. The first actual research in this country was the Survey of Nursing Education in Canada, which was a joint project of the Canadian Nurses' Association and the Canadian Medical Association. It was conducted by Professor George Weir, head of the Department of Education in the University of British Columbia. Commenced in November, 1929, the Report was published in 1932. Although by no means all of its recommendations have been carried out, particularly those regarding the general organization and control of nursing, it has exercised a great influence on nursing and nursing education in Canada. This project cost $32,000, 70 per cent of which was paid by the Canadian Nurses' Association and 30 per cent by the Canadian Medical Association.

The health surveys, conducted by the provincial governments in connection with the Federal Health Grants in 1949 and 1950, included very extensive surveys of nursing. It is hoped that considerable information about nursing will be available from these.

In 1948 the Canadian Nurses' Association initiated a piece of research in the form of a demonstration school, of which the principal purposes were to find the possibilities of improvement in nursing preparation in a school financially and administratively independent of a hospital, and to see whether, given control of the students' time, an adequate bedside nurse could be produced in a period shorter than three years. This has been financed by a grant from the Canadian Red Cross Society of $40,000 a year for four years. An evaluation of this program is now being made.

In 1950 a study of the Association itself was initiated and, in 1951, it

was decided to commence an activity analysis of nursing.

At this point it was realized that the Canadian Nurses' Association was embarking on research and, before further studies were considered, it seemed desirable to attempt to define the total field of required research, even if only in diagram form, and to achieve a unity in which specific projects could find their place. This was particularly necessary as, without doubt, projects would be undertaken in whatever order, opportunity, and assistance might make them possible.

THE PLAN OF RESEARCH

Research was obviously needed in professional and public relations, in nursing education and in nursing practice. Much help was obtained from the study of various research programs, particularly of the Master Plan of the American Nurses' Association. The Canadian plan is also broken down to three areas: as in the American plan, the first two areas are the functions of the nurse and her education for these functions but the third is the organized profession. This plan is not meant to exclude the important question of public relations, which will be considered in all three areas and especially in the study of the Association itself.

CURRENT RESEARCH

It must be borne in mind that, while Canadian nurses have the same problems as American nurses, their numbers are smaller and their financial resources not as great, even proportionally.

The Canadian Nurses' Association has under way at present three projects:

1. *The structure study of the Association:* This was commenced in January, 1951, and the report is expected in June, 1952. The study is being made by a special committee of the Canadian Nurses' Association and a director who is a graduate in public administration. The cost is $10,000 which will be paid by the Association.

2. *The head nurse activity study:* This is regarded as the first step in a possible functional analysis of nursing. It was a four-month study in one general hospital that was carried on from September to December, 1951, by the Research Division of the Department of National Health and Welfare, with the assistance of a nurse research worker and a consultant from the Canadian Nurses' Association. It is hoped that the method used may be made available to other hospitals. The cost will be about $5,000 which will be paid by the Research Division.

3. *Evaluation of the Demonstration School, Windsor:* This is a three-month study which was commenced on October 1, 1951, as the demonstration program was entering its last year. The director is an eminent Canadian educationist of very wide experience in the field of general education. For his consultation there is a joint committee of the Canadian Education Association and the Canadian Nurses' Association.

This evaluation is planned as the first stage of a much broader examination of nursing education across the country. It is expected that the same director will be able to go on immediately to a six-month comparative study of several three-year hospital school programs. It is hoped that this can go on, before too long, to a nation-wide survey of nursing education at all levels.

The cost of the first two stages will be $10,000, to be paid by the Canadian Nurses' Association.

℞ *Chuckles* P.R.N.

I well may flunk my R.N.'s when I sit for them next Spring,
But compared to that other horror this would be a minor thing.
I live in nameless terror lest on that day my pen
Should win me immortality in ℞ Chuckles P.R.N.

Lyle Creelman *Writes . . .*

RECENTLY I HAVE had an opportunity of attending a meeting of experts on women's work—an Expert Committee of the International Labor Organization.

The ILO is, as you know, one of the oldest of the specialized agencies associated with the United Nations. During some of the war years it was located in Montreal. It has been pleasing to me, in talking to many of the members of the Secretariat of that organization, to learn how much they liked being in Canada.

ILO is the agency which endeavors to work out international solutions of pressing labor and manpower problems. It differs from other specialized agencies in that it is a "tripartite" structure: that is, its conferences are composed of representatives of employers and employees as well as representatives of member governments. ILO now has 65 members—almost as many as WHO. A large part of its work is concerned with drawing up conventions. If these conventions are ratified by the member countries, legislation is supposed to be put into effect to make them legal. Though countries may not ratify the conventions, they are expected to examine them and to report to ILO from time to time concerning the state of local law and practice. In this way ILO conventions influence standards even in countries where they have not been ratified. Some of the conventions which have been ratified call for minimum age of admission to employment, protection of wages, holidays with pay. Some of them provide for maternity protection, regulate night work for women

Members of meeting of Experts on Women's Work and Secretariat of I.L.O. MRS. FIGUEROA GAJARDO, *chairman, is centre front.*

and the young, forbid employment of women in mines, forced labor and peonage.

To return to the meeting which was held here in Géneva, December 11-15, women experts in the field of employment attended from Australia, Chile, France, India, Italy, the United Kingdom, and the United States of America. Mrs. Ana Figueroa Gajardo was a most capable and charming chairman. You may have noticed her name in reports of the United Nations Assembly in Paris, as she was elected the first woman chairman of the Social Commission of the United Nations.

ILO had provided a great deal of background material for the representatives as a basis of discussion. You probably have realized that one of the jobs of the Secretariat of any of the international organizations, in preparing for the various meetings, consists of collecting such background information. It is the work which goes on beforehand and behind the scenes. Did you know that in 1950 it was estimated that approximately 20 per cent of all Canadian women were in gainful employment and, of those, about 25 per cent were married? In this connection it is interesting to note that in the U.S.A. more of the employed women are married than are single. In October, 1939, in Canada 569,000 women were employed. By May, 1951, this figure had risen to 1,098,000. The applications for jobs at the end of September, 1950, were still more than one-third higher than in 1949, since numbers of married women who had not worked for several years were coming again to seek employment. This was largely on account of the high cost of living.

During the discussions the necessity for the staff of a placement service to be fully aware of employment opportunities for women was stressed. Attention was given to the fact that so frequently the accustomed employment for women is all that is considered. Opportunities are not sufficiently sought in occupations which have not previously been considered as acceptable for women.

Of course, the subject of equal remuneration was good for a great deal of discussion. In many countries women doing the same work as men, though equally qualified, have lower remuneration. For example, in Australia the industrial wage rate of women is 75 per cent of men's rates (formerly this was 54 per cent). In Luxembourg the differential is 10 per cent. In France the law provides for equal remuneration for equal work in all contracts. Naturally the group were of the opinion that unequal pay was not fair and made strong recommendations for equal pay for equal work, following adoption by the ILO of a new convention on that subject in June, 1951.

The Committee was concerned with the need for social measures and community services for the working women with family responsibilities.

One of the conventions of ILO refers to maternity benefits. This convention is being revised and it is hoped that more member governments will ratify the new proposals which will allow for a longer period of absence from work with pay than previously. The need for nurseries and nursery schools in which the child could be placed and which would be staffed by well trained personnel was emphasized. In some countries these services are much more highly developed than they are in Canada. The Committee also felt that school meals at a low cost, or free of charge, should be available for the children of those mothers who are working. They went so far as to say that such a service should be continued during the school holidays. Some of us who had been teachers wondered how practical this would be. One delegate quickly suggested that this would be an opportunity to make use of those women who could only do part-time work and thus would be killing two birds with one stone.

The Committee even considered practical steps to make household tasks easier, such as the construction of cheap and functionally planned houses and the provision of modern household equipment. They thought,

too, that cheap services, possibly on a cooperative basis, might be provided to facilitate such household tasks as washing, ironing and mending, and that stores should be open during more convenient hours.

There was interesting discussion in relation to vocational training, the majority of the experts feeling that domestic science should be included in the general compulsory education for boys as well as for girls. Some of the delegates thought that the men of their countries would not take very kindly to this idea. However, the majority considered that this in itself would assist in changing the attitude of men towards their partnership in work and in the home.

Perhaps in Canada and the United States men have already accepted this responsibility to a much greater extent than in many other countries.

The Committee was very conscious of the fact that greater efforts must be made to attract more girls and women into the professions of teaching, nursing, midwifery, and social work. They stressed, too, that the training for these professions would have to be adapted to the social and economic conditions of the area or region and that the training should seek to raise the level of these professions.

I should have mentioned that there were representatives of UNESCO and FAO at this session. We always welcome the opportunity to attend meetings of other specialized agencies of the United Nations and never fail to be impressed with the interdependence of the work. Education, good nutrition, health, favorable working conditions—all are the right of every individual in every country.

Word Game

Did you enjoy making up words from the letters in last month's game? You will be astonished by the number that can be found in this month's combination. By the time we had dug up 216 we decided it was almost too easy. Next month we will have to try a more difficult diagram.

You know the rules—move in any direction you wish in linking up letters, but no skipping or repeating the same letters unless they occur more than once. One of the longest words this time is E - D - U - C - A - T - I - O - N. Find it? (*Turn to page 153 for our list*)

M	F	E	U	S
G	O	D	C	H
B	L	A	T	I
P	E	R	N	O
V	Y	K	U	J

Industrial Nursing

It is of interest to note that, in its October issue, *Nursing World* dedicates a section to the industrial nurses of Canada. Three Canadian nurses were contributors, namely—Miss Jeanne Favreau, who gave a brief review of industrial nursing in Quebec; Miss Mildred Walker, who discussed personnel policies, and Miss Sarah Wallace who went into considerable detail on the relative values of long- and short-term preparatory periods of training for industrial nurses.

All the Latest Improvements

A student nurse, who had been awarded a bursary by the Royal College of Nursing and who chose to spend her time in a neurological hospital, writes a very interesting account of her experience at the Serafimer Hospital in Sweden, in the *Nursing Times*, Nov. 3, 1951, issue. Speaking of the Sodersjukhuset which she visited and which is reputed to be the most modern of European hospitals she said "they even provided bicycles for use along the corridors."

Public Health Nursing

Recording — A Means to an End

ALICE G. NICOLLE

RECORDING IN public health nursing cannot fail to be interesting if the emphasis is placed on the unfolding drama of a human family rather than on the record form which, after all, is only a piece of paper or cardboard, inanimate and useless, until it is brought to life by the recording hand of the public health nurse. Without the recordings of interested men and women throughout the ages, history, the story of man's development, his hopes, fears, needs and wants, and his changing ways of meeting them, would be as a closed book. There would be little or nothing to explain our present way of life nor to stir us to work and plan for a better way for those who follow us.

Some will say that the analogy is not a good one. The historian has a special interest which may not be ours in public health or public health nursing, yet the basic reason is the same—an interest in the lives and ways of a people inspiring us to find and to write about those phases of their lives which have a significance in order that we may better understand and serve them.

Much has been said and written in public health regarding the importance of beginning where people are, of teaching from the known to the unknown. Have we been wrong in our thinking or are we only now beginning to see that it also means that we must start with what we know about a person or a family, not only what we know of their racial, economic, and educational background — important as these are — but their ways of thinking and feeling about life; what their experiences mean to them? It is here that our recordings in public health nursing assume significance. Where but in the service records of a district nurse's file will one find the information necessary for the guidance of a family, or of any one of its members, be he a school child, an adolescent, the parent of a newborn baby, or the distraught son of an aging senile mother who is disrupting his household?

Yes, recording is as vital to the development of public health and public health nursing services as it has ever been. Without it, there can be little continuity and less progress.

Why, then, does the subject of recording still arouse so much controversy; still take up so large a part of any discussion or conference on public health services? Can it be because development in this phase of the work has not kept pace with the ever-increasing availability of scientific knowledge and the rapid expansion of community services during the past two decades?

In the Report of the Study Committee on Public Health Practice in Canada, one cannot help but compare the very brief section on recording (page 23) with the breadth of activities mentioned throughout the remainder of the Report. It might be well to pause and to remind ourselves that in its 78 pages this Report in itself is a demonstration of the value of anecdotal, narrative and numerical recording, and of recommendations for further action. What can we learn

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from this survey of public health practice across Canada that will stimulate study and action in relation to the present methods used in the recording of local health work as it is related to public health nursing?

Under the title of Recording on page 23 of the Report, the following related but differing practices are commented upon:

> The availability of vital statistics to the medical officer of health and their value as a basis for planning that part of the service known as maternal and child health.
>
> Daily reports regarding the kind and amount of work covered each day by the public health nursing field staff, including lectures given and pamphlets distributed.
>
> Concurrent time analysis or survey by the public health nurse.
>
> "Frequently, basic family information is repeated on each record; however, some agencies are developing a family folder."

Below a sub-title, Recording in Public Health Nursing, is this statement: "Many of the records used by the (public) health agency are completed by the public health nurse." Shall the challenge of this section and this statement be accepted without question? Should this still be the picture of the public health nurse's responsibilities for recording? Is it the best use of her time in 1952?

In the earlier years, public health nursing services were carried on to a considerable extent in one-nurse districts, often isolated and, in official agencies, with only the part-time service of a medical officer of health. Methods of recording, usually simple, were developed to meet local needs. It naturally and invariably became the responsibility of the public health nurse. To these faithful workers we are indebted for figures as well as other tangible results which still show the effect and the value of earnest effort to promote health services. Rapid expansion of services, however, to cover large areas of our country has changed the picture from one-nurse districts and relatively simple recording to larger staffs and a highly complex system using statistical method, research, and intricate office equipment such as the visible index and a multiplicity of forms and reports. The question seems not only to be who shall be responsible for recording but what part of all this complex system can be termed recording.

If public health nurses, over the years, have been responsible for the greater part of recording in public health agencies and are still carrying this responsibility, and if they are convinced that the time has come or, in fact, is overdue for workers better prepared than they to take over a part of this work, does it not follow that the nurses themselves should be prepared to explain their position in regard to the legitimate place of recording in public health nursing and to assist in or even initiate a careful survey of recording and reporting as it applies to public health nursing and the work of the nurse in the district?

What are our responsibilities in a community health program? What part of recording is clearly the responsibility of the public health nurse and an essential part of family health work and why? What contribution can each public health nurse make now, in her own district and agency? Following her interviews with at least two families, she can carefully scrutinize what she has recorded in relation to its usefulness in the continuity of work with them in home, clinic, or school. Could someone else record this information?

What part of her daily report does the public health nurse use in assessing her own progress, her ability to plan her work, to improve her planning, and to reveal undeveloped areas of work? What part of reports or recordings are necessary to the supervisor if she is to guide and encourage the staff nurse to develop her potential abilities and, through her, to ensure a developing and increasingly valuable service to the families of the community?

Have we looked for undiscovered merits in our present system of recording? A well-known educator, Sir Fred Clarke, once wrote this note on a student's essay on modern education: "Think out your philosophy of *change*

more fully. You still fall too readily into the popular habit of overworking the adjective 'new.' Remember Milton's new presbyter is but old priest, writ large, and so, too, new education may be but old prejudices transformed and triumphant." We, too, must be sure that in promoting new methods and in attempting to discard what is obsolete we do not also discard much that is valuable.

Coding as a method may be used as an illustration. The Report of the Study Committee on Public Health Practice in Canada on page 23 points out that many columns, with headings such as breast feeding, etc., "leave little space for narrative which is so important." Does this mean that we should eliminate columns which provide for coding, using only narrative, or shall we plan sufficient space for narrative recording by another arrangement—for instance, using the breadth rather than the length of the form thus providing space for both coding and narrative recording. How is a code used? What is its value?

Within the last few years, many situations have been observed by the writer in child health conferences and clinics and in interviews with expectant mothers. It was said that a code was being used to indicate "what the nurse had taught." There was apparent confusion as to the use of the space provided for narrative. Neither was being used to advantage. After careful observation and evaluation of what actually happened in an interview between a nurse and parent, it was agreed that the best use of the code was to record what was observed and heard by the nurse and considered significant. In this way, she could plan her teaching in order of importance as she glanced at the symbol in the column. The space for narrative was available to enlarge upon the needs indicated by the code and for other necessary data — viz., the mother's questions, strengths or plans, the physician's recommendations, the nurse's suggestions to meet immediate needs, or the results of former interviews beyond what was evident in the code.

The effect of this change in thinking upon the quality of recording as well as the satisfaction of the recorder seems to have made for a clearer understanding of the value of a code. Where this method has been taught and is understood—in other words, learned, by those who use it—the code provides for a minimum of writing when the nurse is listening to a mother or to other members of a family. A symbol such as 3 - 2 or 0 guides her thinking and planning without the necessity of reading a sentence or paragraph. Previous narrative can be read before the interview begins and notes added as the mother dresses the baby.

Much is now being said about "the importance of narrative recording." The increasing emphasis on child development, mental health and psychiatry, on guidance and counselling, and the obvious contribution which every public health nurse could make, and in many cases is making through her family health work, has no doubt forced us to reconsider the emphasis on brevity in narrative recording.

The question immediately arises as to the housing of files for this increasing volume of recording. The answer lies in summarizing at regular intervals. A summary of family recording keeps the files "within bounds"; it also offers to the staff nurse and supervisor the opportunity to pick out essentials, measure progress, and to see the situation in its broader aspects —a truly valuable learning experience.

One cannot leave the matter of narrative recording without briefly considering the difficulty which written expression presents to many nurses entering the public health field. Universities make a valiant effort to teach the philosophy and principles of recording. They cannot be expected to teach the methods of any one agency or area (see The Report, end of page 53). This responsibility must be accepted by the public health agencies and be implemented through orientation, supervision, and staff education.

Interest and skill is developed in the field where recording is best taught as

each new nurse participates in a procedure or activity. One would hope that, as basic nursing courses include more of the health and social aspects of living, time will be available in university courses to consider communication skills to a greater degree.

In developing record forms, a decision must first be made as to what information the public health nurse as a family health worker should record and how the data are to be used in promoting the best type of service in the community. When such decisions have been made, the content and arrangement of material on such forms, their size, and the recording procedure can be determined. At this stage in the planning of meaningful records which will meet day-to-day service requirements, as well as any subsequent statistical needs, the advice and collaboration of a public health statistician or other person with experience in the designing and utilization of records should be sought.

If the Report of the Study Committee on Public Health Practice in Canada is to be implemented and the cost and effort made to achieve results, we must heed the statement made on page 7 of the Summary: "Policy develops with experience. There is a pressing need for more research and experiment at the local health agency level."

The challenge is held out to public health nurses across Canada to study their own situations and make recording one of the means to a worthy end —the enhancement of public health nursing service.

Nursing Sisters' Association

Twenty-five years ago almost to the day, members of the *London Unit* met for their first anniversary dinner at Bungalow Tea House (now known as Cobblestone Inn). This fact was disclosed by Della Birrell, immediate past president, when she read a résumé of the association's history at the Silver Anniversary armistice dinner held recently at the Inn. A large birthday cake, donated by Mrs. C. Brown, the unit's first president, centred the head table.

Present at the dinner were former nursing sisters and home sisters who served overseas and in Canada with the army, navy, and air force. Now out of uniform, they serve as housewives, nurses, nutritionists, physiotherapists, and occupational therapists.

Among those at the head table were past presidents: Mmes J. Beattie, W. L. Mara, C. Jackson, and Miss H. Collier. They were introduced by M. Rutherford, president. Present also were guests from Belleville, Palmerston, and Victoria.

Convener of the celebration was Mrs. J. A. Morgan, assisted by C. Cuthbert, Mmes H. Logan, J. D. Cowie, and L. M. Pepler.

The annual dinner meeting of the *Prince Edward Island Unit* was held at the Charlottetown Hotel in November. A business session followed dinner when the following officers were appointed for 1952: President, M. Wilson; vice-president, Verna Darrach; secretary-treasurer, Dorothy MacKenzie. It was decided to send "comforts" to the Canadian troops in Korea and G. McCaron was appointed convener of this project.

Gardening

Many people would be more enthusiastic about gardening if it were possible to plant seeds and have them grow without further work or worry caused by weeds and drought. This utopian state of affairs may never arrive but aluminium foil is providing a fairly good substitute for it. Used as a mulch, the foil is laid in strips between rows of growing plants, thus eliminating the weeds between the rows and enabling the plants to derive the maximum benefit from the moisture in the ground with a minimum of watering.

Tests with 17 kinds of vegetables indicated that aluminium is especially valuable during periods of moisture shortage. It increases the yield of the vegetables, increases the initial growth, plant development and harvest. Aluminium foil appears to be valuable also in reducing the ravages of insects. The technique is simply to place it between the rows of vegetables and cover with a little earth to hold it in position. — *Aluminium News*

Institutional Nursing

Care for Our Native Canadians

F. Elva Taylor

The Charles Camsell Indian Hospital, an institution for the treatment of tuberculosis among Treaty Indians and Eskimos, was opened in Edmonton, in January, 1946. The main building was formerly a Jesuit college which had been sold to the Americans for engineering headquarters during World War II. They built a number of redwood buildings for living quarters. After the Americans left, six of these were converted into a hospital unit and connected by corridors to the main building by the Canadian Army. With the cessation of hostilities in the Japanese theatre of war, this hospital was turned over to the Department of National Health and Welfare and now we have a 500-bed establishment.

Miss Taylor is matron of the Charles Camsell Indian Hospital at Edmonton.

Our patients come from the province of Alberta, northwestern Saskatchewan, the western part of the Northwest Territories and the Yukon. The majority of the patients come to the hospital because of tuberculosis discovered by the x-ray survey teams which are sent out each summer from the Camsell. Others are sent in by the doctors or public health nurses who look after the different areas. As a point of interest, we had 390 Indian patients, 48 Eskimos at the end of September, 1951. The remainder are D.V.A. or civilians from the Northwest Territories.

The older patients from Alberta and many of the northern areas do not speak English, so we try to keep those who speak the same language together if at all possible. At first they were reluctant to come to the hospital and thus be separated from their families. Now, however, many

Airview Photos

Charles Camsell Indian Hospital and staff quarters, Edmonton

of their relatives have gone home with the disease arrested, so they do not raise many objections.

The Eskimos come from faraway places like Cambridge Bay, Bathurst Inlet, Reid Island, Aklavik, and Coppermine. Those from near Aklavik frequently speak and understand some English but many of the others do not. They adapt themselves readily to hospital life and are soon able to make themselves understood by signs and a few essential words which they learn quickly. The Eskimos are a happy race and do not seem to fret at having to stay in bed. We try to arrange that there will be two Eskimos together in a ward, especially if they do not speak English. Their language is common to all but those from different areas have different dialects and are not always able to understand each other.

The surgical ward is very active. During the past year stages of thoracoplasty were done, as well as lobectomies, orthopedic and minor surgery.

We run a fully recognized school, staffed by qualified teachers who give individualized instruction to both children and adults. Many of the older people are learning to read and write and are most interested, especially in reading. There are over 300 who are doing various levels of school work, ranging from the primary grades to high school subjects. The showing of films, which are both instructional and recreational, is another phase of the educational program. The teachers project these films right in the wards and arrange the schedule so that each ward has one showing a month. This provides an excellent diversion for the patients. *The Camsell Arrow*, a hospital paper which provides a liaison between the patients, staff and patients, and hospital and home, is published bimonthly.

Tug-of-war at the picnic

The Indian and Eskimo women follow their native handicraft when their physical condition permits. They do leather work, beadwork, embroidery, and some knitting. Some are learning to crochet. They make everything from lapel ornaments, moccasins and mukluks to tea cloths and bedspreads. The men have shown considerable skill in making photograph and autograph albums and picture frames.

Every July we have a patients' picnic. Those who are well enough to attend look forward to this event with great enthusiasm. This year we had easy games like throwing darts at balloons and shooting down packages of cigarettes with pop-guns. For further entertainment the staff drew names of the patients and were their representatives in sack races, three-legged races, tug-of-war, and so on. Each gave the prize money to the patient they represented. The tug-of-war of the doctors against the orderlies is always a highlight of the day. The children eat so much ice cream and drink so much pop that we are always expecting disastrous consequences! So far we have been fortunate in having no casualties!

Christmas is the other great occasion for the patients. The different bands send in money through the Indian agents and several of the service clubs in the city make financial donations. This is pooled and used to buy a gift for every patient in the hospital. These are always useful articles. As far as possible they are things that have been requested—sweaters, slippers, socks, and fountain pens. The children receive appropriate toys. The rooms are decorated and a Christmas tree is put up in each ward. Santa Claus, followed by several members of the staff to distribute gifts, makes his visits every Christmas Eve. Christmas morning is ushered in with carols sung by a few early-rising members of the staff.

Let's see how it works!

Slightly overwhelmed

Dinner is served at 11:30 a.m. and as many patients as are able sit at tables which have been placed in the wards. Although they are away from their families, most of them enjoy themselves hugely. The staff certainly does too. A number of the men's and women's clubs of Edmonton bring gifts to the patients during Christmas week, the children being especially well remembered.

The incidence of tuberculosis in the southern section of Alberta has been decreasing steadily and we hope that the next five years will show as much accomplished in other areas.

Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments—Hamilton: *Shirlie Bishop* (St. Joseph's Hosp., Hamilton), *Beatrice McLea* (Toronto Western Hosp.), and *Florence Stewart* (Toronto Gen. Hosp. and University of Toronto). Lincoln County, Ont.: *Clara Hood* (Gen. & Marine Hosp., Owen Sound). Montreal: *Mrs. Norma Baldwin, B.Sc.N.* (Saskatoon City Hosp. and Univ. of Sask.), *Lois Boast* (Montreal Gen. Hosp.), and *Lucille Poulin* (St. Mary's Hosp., Montreal). Ottawa: *Mrs. E. Boyd* (Toronto Western Hosp.). Saskatoon: *Mrs. Bessie Adair* (Moose Jaw Gen. Hosp.). Timmins, Ont.: *Sheila Rymer* (Royal Victoria Hosp., Montreal). Toronto: *Gwendolyn Cowan* (T.G.H.), *Frances Cox* (R.V.H., Montreal), *Marjorie Scott* and *Lenora J. Steed* (T.W.H.). Waterloo, Ont.: *Iris Burke* (Ont. Hosp., New Toronto). Winnipeg: *Sandra Maciver* (Winnipeg Gen. Hosp.).

Reappointments—Toronto: *Mmes Donna Hollowell, Shirley Pentland.*

Transfer—*Marjorie Stibbards* from Surrey, B.C., to Burnaby, B.C.

Leave of Absence—Ottawa: *Vivian Adair.*

Resignations—Amherst, N.S.: *Mrs. Mary Jackson.* Guelph: *Mrs. Audrey Leader.* Hamilton: *Mrs. Ruth Drysdale.* Richmond, B.C.: *Jean Webster* as nurse in charge. Sudbury: *Maud Rhodes.* Toronto: *Florence Sinclair, Jessie Wallace.* Vancouver: *Mrs. M. Fetherstonhaugh.*

Candles will burn more evenly and more slowly if kept in the refrigerator 24 hours before lighting.

Aux Infirmières Canadiennes-Françaises

Soins Infirmiers des Traumatismes et des Brûlures

COLETTE TARDIF

LA PROFESSION d'infirmières veut que tous ses membres veillent au bien-être de la société. Aussi, en face de la situation mondiale actuelle, aucune de nous ne peut rester indifférente. Afin d'assurer la sécurité publique, il faut dès maintenant instruire la population entière des règles à suivre en cas d'urgence. Si quelque désastre survenait, il faudrait de plus secourir tous ces blessés dont on ne peut jamais prévoir le nombre. Infirmières, voilà où nous pouvons servir. Sommes-nous prêtes à commencer la tâche? Avant d'entreprendre l'éducation et le soin de nos semblables, il faut bien s'assurer de la solidité de nos connaissances. Ce cours de défense civile nous est précisément donné dans ce but. C'est donc avec la prétention d'apporter à la cause commune ma modeste contribution, que j'ai accepté de vous présenter ce travail.

Dans le chapitre qui m'a été confié, je ne ferai que reviser brièvement les principes fondamentaux du nursing concernant les traumatismes et les brûlures. Car il ne s'agit pas de communiquer une science nouvelle, mais bien de rappeler à la mémoire des notions déjà existantes dans votre pré-conscient. L'importance du chapitre est toutefois assez considérable puisque les traumatismes et les brûlures, nous le savons, constituèrent les principales causes de mortalité dans l'expérience inoubliable d'Hiroshima et de Nagasaki.

Mlle Tardif, institutrice à l'école d'infirmière de l'Hôpital Notre-Dame, Montréal, a pris part à la conférence lors des cours de la Défense Civile sur "Les Aspects du Nursing dans la Guerre A.B.C."

Nous traiterons, premièrement, de la responsabilité de l'infirmière en cas d'urgence; et, deuxièmement, du traitement et des soins des fractures, du syndrôme d'écrasement, des blessures abdominales, des blessures thoraciques, et des brûlures.

Voyons donc, en premier lieu, *notre responsabilité en cas d'urgence.* Inutile de rappeler que pour agir efficacement, il faut tout d'abord rester maître de soi. En pleine possession de toutes nos facultés, il sera plus facile d'apprécier exactement l'état du malade et c'est là notre premier devoir. Pour s'en acquitter convenablement, il est donc essentiel de connaître les signes et symptômes des différents traumatismes et brûlures.

Dans notre appréciation, il ne faut pas uniquement considérer les besoins physiques. Le rétablissement psychique du blessé doit aussi nous intéresser.

Cette évaluation terminée, le traitement approprié sera appliqué le plus tôt possible. Les ordres permanents spécifiques aux différentes situations d'urgence seront ici notre meilleur guide. Notre devoir est donc de nous renseigner parfaitement sur ces directives.

Connaissant l'étendue de l'organisation d'un service médical en défense civile, vous conviendrez avec moi de la nécessité de consigner des renseignements précis sur la fiche de chaque malade. Les remèdes administrés, l'application de tourniquet et tous détails pouvant déterminer un traitement spécial seront notés afin de rendre possible le travail d'équipe.

Quand on le peut, on s'empresse ensuite d'obtenir des directives médicales afin d'alléger nos responsabilités

et d'assurer au malade un meilleur traitement.

Dans un cas d'urgence, il faut de plus s'astreindre à organiser les soins infirmiers sur une base sélective. Des priorités d'évacuation seront donc établies: notre première considération ira aux blessés souffrant d'hémorragies, de blessures à la poitrine, d'état de choc, et de brûlures. Viendront ensuite les blessures à l'abdomen, à la tête, et aux extrémités.

L'infirmière ne peut naturellement s'acquitter seule de toutes ces tâches; voilà pourquoi on lui assigne des aides qu'elle doit cependant diriger et surveiller. A tous, elle fera comprendre l'utilité d'une bonne coopération.

Et nous arrivons aux traitements et soins proprement dits des traumatismes et brûlures. Les brûlures graves, ainsi que certains traumatismes, entrainent souvent un état de choc qu'il est essentiel de contrôler en premier lieu. Les mesures usuelles de traitement du choc sont toujours applicables: procurer de la chaleur; donner la position horizontale ou déclive; soulager la douleur.

Après avoir dit un mot du choc, nous pouvons maintenant aborder les fractures. Pour les infirmières comme pour les médecins, le but des soins orthopédiques demeure le même, à savoir: préservation et restauration des fonctions de l'appareil musculosquelettique.

Et voici *les généralités concernant les fractures:*

Il faut tout d'abord savoir reconnaître la fracture chez un blessé. En soulignant qu'une fracture se définit solution de continuité d'un os, nous verrons quels en sont les symptômes: le malade accusera de la sensibilité, de la douleur; nous pourrons remarquer du gonflement, de l'impotence fonctionnelle en un point où il y a souvent rigidité, crépitement, difformité, et même décoloration de la peau. Dans les os longs, il y aura, en plus, raccourcissement du membre, dû à la contraction des muscles insérés au-dessus et au-dessous du siège de la fracture. Ces symptômes varieront avec les différentes fractures. Dans les fractures linéaires ou limitées à une fissure, dans les cas où les surfaces fracturées se maintiennent ensemble, plusieurs symptômes pourront manquer.

En deuxième lieu, il importe d'appliquer les mesures d'urgence appropriées. On sait que le traitement essentiel des fractures consiste en la réduction qui se fait ordinairement sous anesthésie. Aussi, faut-il confier ces malades le plus tôt possible au médecin qui y procédera après confirmation du diagnostic par des examens de rayons-x. Avant d'opérer le transport du blessé à l'hôpital, on rendra le membre fracturé aussi immobile que possible à l'aide d'attelles improvisées—planchette, canne, etc.—fixées par-dessus les vêtements par des bandages. Le meilleur moyen de réduire les vives douleurs qui accompagnent les fractures est d'immobiliser en plus, les articulations qui se trouvent au-dessus et au-dessous du point affecté. S'il y a fracture ouverte, il faudra aussi protéger la plaie. A ces blessés, on peut administrer de la morphine, ce qui calmera l'anxiété toujours présente.

Comme troisième remarque, disons qu'il faut prévenir les complications. Dans le maniement du blessé, on ne doit jamais oublier les complications pouvant résulter d'un traitement d'urgence mal appliqué: aggravation des lésions tissulaires; état de choc dû à la douleur ou à la crainte; infection, surtout dans les fractures ouvertes et plus particulièrement lorsqu'il y a eu exposition à la radiation résiduelle.

Vient ensuite l'évacuation du blessé qui doit se réaliser avec le minimum de manipulations et de retard. Après avoir énuméré les complications d'interventions intempestives et mentionné que le traitement relève du médecin, il est inutile d'insister sur les raisons du transport rapide et minutieux du blessé à l'hôpital.

Là, le médecin procédera le plus tôt possible à la réduction, manuelle ou sanglante. Après avoir rapproché les fragments osseux, afin de leur permettre une bonne union, il les maintiendra en place par divers appareils orthopédiques. Nous devons donc comprendre les principes et les fins

des principaux appareils en usage:

(a) Attelles de bois simples, attelles métalliques à angle droit, attelles de Thomas, servant dans un grand nombre de fractures, principalement dans celles du membre supérieur.

(b) Des bandages plâtrés sont encore employés comme moyen d'immobilisation.

(c) On se sert aussi d'appareils à traction, dont voici simplifié le mécanisme: des pinces traversant l'os ou des diachylons appliqués sur la peau sont reliés, par une poulie permettant au malade de se mouvoir, à un poids qui fait la traction continue.

Malgré ces appareils, on ne doit pas négliger le confort du malade, mais jamais on ne se permettra un déplacement de l'appareil sans l'autorisation du médecin.

Une fois le traitement permanent institué, l'esprit d'observation doit être exercé à la surveillance des réactions du malade: s'il accuse de la douleur, on la rapporte aussitôt au médecin qui vérifiera s'il n'existe pas, en quelqu'endroit de l'appareil, un point de friction ou de pression trop intense. Corrigé immédiatement, ce détail n'entraîne aucune conséquence mais nous savons toutes qu'une négligence de cet ordre peut amener des troubles circulatoires assez graves.

Pendant l'immobilisation qui nécessite souvent un séjour prolongé à l'hôpital, le confort physique et mental du malade doit nous préoccuper: pour réaliser le premier, l'infirmière en orthopédie acquerra des connaissances spéciales concernant le bon fonctionnement des différents appareils et la prévention d'escharres ou de plaies. Au sujet de ces dernières, il faut savoir qu'il est facile de les prévenir par l'emploi de coussins pneumatiques ou de coussinets ouatés. Pour assurer le confort mental, il s'agira, en se basant sur la psychologie du malade, de maintenir une ambiance agréable. Des occupations thérapeutiques bien organisées sont aussi indiquées.

De plus, une diète bien balancée et toujours présentée de façon appétissante est nécessaire à ces malades. Car ils doivent ou conserver leur résistance, ou lutter contre les agents microbiens ou encore reconstituer leurs forces. S'il y a eu irradiation, l'augmentation de la résistance est importante surtout durant les 10 à 14 premiers jours, période latente de la maladie.

Quand on a bien compris les points importants du traitement des fractures et qu'on les a appliquées d'une façon intelligente, notre malade arrive facilement à la phase du rétablissement et de la réadaptation. Encore alité, il doit exécuter les différents exercices recommandés par le médecin. Quand le lever est permis, c'est à l'infirmière d'encourager l'activité qui maintiendra l'intégrité des muscles dans les parties non immobilisées. Le convalescent coopérera d'autant plus qu'il comprendra l'utilité de ces exercices. Ici et dans l'enseignement des soins personnels, l'infirmière a une belle occasion de pratiquer ce rôle d'hygiéniste tant recommandé par le nouveau concept du nursing. Et voilà pour les traitements et soins des fractures en général. Un mot maintenant sur certaines fractures particulières:

Les fractures du crâne: Nous sommes ici dans le domaine de la spécialité car ces fractures relèvent de la neurochirurgie, non à cause de l'importance de la fracture elle-même, mais à cause des lésions cérébrales qui peuvent en résulter. Tout traumatisme à la tête, si léger qu'il nous paraisse, doit donc faire l'objet d'une surveillance médicale pendant plusieurs jours.

Revisons les symptômes des traumatismes crâniens qui dépendront plus de la répercussion sur le cerveau que de la lésion locale.

Lorsque le cerveau est lésé assez gravement, il peut y avoir état de choc: perte de connaissance, pouls faible, respiration superficielle, téguments froids et pâles, baisse de la tension artérielle. Dans ce cas, la première chose à faire est de contrôler le choc. Dans les fractures de la voûte du crâne, nous aurons un gonflement du siège de la fracture, ce qui nécessitera l'aide des rayons-x pour établir un diagnostic précis. Dans les fractures de la base du crâne, nous rencontrerons plutôt un saignement ou un écoulement de liquide incolore par le nez, le pharynx, ou les oreilles.

Le premier provient d'une hémorragie et, le second, du liquide céphalo-rachidien. Le sang peut aussi apparaître sous les conjonctives, ce qui donnera de l'ecchymose du pourtour des yeux. Ces symptômes étant très importants pour le diagnostic, il ne faut jamais omettre de les rapporter.

A cause des complications immédiates et tardives possibles, il est nécessaire de prendre et de consigner régulièrement, aussi longtemps que demandé, les caractères du pouls, de la respiration, de la tension artérielle, et de l'état de conscience. L'écoulement par les oreilles, les céphalées persistantes, l'hyperpyrexie, la rigidité du cou, la photophobie, les mouvements convulsifs, les symptômes de paralysie sont autant d'observations qui peuvent aider le médecin dans le dépistage précoce des complications. Il ne faut pas abuser, chez ces malades, des stupéfiants car ils voilent ces symptômes de complications. Cependant, il est possible de prévenir l'agitation en veillant au confort du malade: atmosphère calme, cathétérisme fait à point, etc.

Comme deuxième catégorie de fractures particulières, nous verrons *les fractures de la colonne vertébrale.* Encore ici, le traumatisme est assez grave pour entraîner un état de choc qu'il faudra combattre en premier lieu. Si la fracture, se produisant à la région cervicale, atteint le bulbe, la mort ne tardera pas à suivre par suite de la paralysie du diaphragme.

A l'endroit de la fracture, on pourra trouver de la difformité, de la sensibilité, du gonflement, mais il est plus important de rechercher les signes de lésion à la moelle: paralysie temporaire (flasque au début, spasmodique ensuite) due à une hémorragie ou à une pression par oedème; perte totale de motricité et de sensibilité dans la région innervée par les troncs sortant de la moelle au niveau de la lésion ou plus bas; c'est ainsi qu'on pourra trouver des modifications circulatoires, des abolitions de réflexes tel incontinence ou rétention urinaire.

Afin de prévenir d'autres lésions à la moelle, le maniement de ces malades requiert une grande attention de votre part. En les levant ou les déplaçant, la colonne vertébrale doit être maintenue en position horizontale.

Quand le mode définitif d'immobilisation ou de traction a été établi, l'infirmière doit se renseigner parfaitement sur les principes et les fins des appareils employés afin d'être en mesure de conserver au malade la position voulue.

Quand l'atrophie musculaire et les contractures sont à craindre, l'infirmière doit encourager une certaine activité chez son malade mais toujours dans les limites permises.

En plus de ces soins spécifiques, il ne faut pas négliger les soins généraux. L'irrégularité des fonctions vésicale et intestinale pourrait être partiellement ou même totalement contrôlée par un lavement quotidien. Une attention particulière est requise pour le soin de la peau car les plaies de lit sont grandement à craindre chez ces malades. Des complications comme les infections urinaires, la pneumonie, les plaies de lit, la distension abdominale pourront donc être prévenues par les bons soins de l'infirmière. Elle s'efforcera aussi de conserver à ses malades un bon psychisme, ce qui facilitera la guérison.

Après les fractures, nous entreprendrons de voir *le syndrôme d'écrasement* ou oedème traumatique. Comme nous sommes en défense civile, nous devons prêter une attention spéciale à cette partie car personne n'ignore que dans une guerre atomique, par exemple, nombreux seraient les blessés présentant ce syndrôme.

Disons tout d'abord qu'il s'associe aux lésions causées par une compression prolongée ou un écrasement majeur des extrémités; souvent il n'existe pas d'indice de plaie extérieure. A quoi devons-nous l'attribuer? On a pensé déjà que ce syndrôme était dû à l'absorption de substances toxiques provenant des muscles écrasés; mais une nouvelle théorie veut qu'il soit causé par la contraction des artérioles rénales sous le stimulant de la douleur, avec libération simultanée de pigments et de myohémoglobine qui se déposent dans les tubes urinifères. Avec cette explication, il sera maintenant plus facile de comprendre comment se manifeste ce syndrôme d'écrasement.

Dans la partie affectée, nous re-

marquerons de l'oedème avec, en certains cas, présence de vésicules sur la peau. Cet oedème traumatique accompagne ordinairement un état de choc grave. Du côté rénal, nous observerons de l'oligurie, bientôt suivie d'anurie et de symptômes d'urémie: vomissements, diarrhée, somnolence, trémulations musculaires, crises épileptiformes, respiration de Cheyne-Stokes, hyperthermie, etc.

Quel est le traitement? Il existe des lois d'urgence à appliquer: devant une plaie ouverte, nous verrons à la couvrir après avoir contrôlé l'hémorragie. Le choc devra aussitôt attirer notre attention. Le traitement comporte aussi l'administration de liquides alcalins en grande quantité. Dès que c'est possible, il faut donner par os toutes les heures une solution de bicarbonate de soude en évitant cependant les liquides contenant du potassium tel les jus de fruits qui empêcheraient l'utilisation du sodium.

Le traitement sera orienté vers la lésion rénale dès que l'oligurie fera son apparition. On procédera alors à une alcalinisation rapide par voie intraveineuse. Dans ce syndrôme, le plasma est aussi nécessaire pour la réparation des pertes subies par les muscles lésés.

La chirurgie interviendra ultérieurement soit pour déterger les tissus mortifiés, soit pour pratiquer l'amputation de la partie affectée dans certains cas plus graves.

Continuant notre revision des soins infirmiers dans les traumatismes et les brûlures, nous aborderons maintenant *les blessures abdominales*. Elles demandent aussi traitement immédiat, assez simple, toutefois, quand il n'y a pas d'hémorragie. Avec une hémorragie, notre blessé deviendrait cas d'extrême urgence. Autrement, dans les blessures abdominales, il s'agit de recouvrir la plaie d'un bon pansement massif sans essayer auparavant de replacer les viscères ou d'enlever les corps étrangers dont on soupçonne la présence. Il n'est pas du ressort de l'infirmière d'explorer une plaie de cette gravité.

A ces blessés, par mesure de prudence, on ne donne rien par la bouche. Mais il est conseillé d'administré un calmant afin de diminuer l'anxiété qui pourrait entraîner de fâcheuses conséquences.

Ces mesures d'urgence prises, il faut évacuer, le plus tôt possible, ces blessés comme "cas de civière." Dans la priorité d'évacuation, on a vu que ces malades viennent après les cas d'hémorragie, de choc et de blessures thoraciques, mais avant les blessés à la tête ou aux extrémités. Quant au traitement ultérieur, il dépend entièrement de la chirurgie et les techniques employées feront varier légèrement les soins infirmiers.

Considérons maintenant *les blessures thoraciques*. Elles peuvent aller d'une simple fracture de côtes aux plaies pénétrantes ou perforantes.

Quels seront les symptômes de ces blessures? Le premier, qui survient aussi dans tous les grands traumatismes, état de choc. Quand il y a lacération des poumons par des bouts d'objets cassés ou par des contusions, on remarquera souvent de l'hémoptisie. Cependant, une hémorragie pulmonaire interne peut survenir sans qu'il y ait hémoptisie. Comme troisième symptôme, mentionnons la dyspnée et la cyanose dont l'intensité variera avec la gravité de la blessure —c'est-à-dire avec l'étendue du parenchyme pulmonaire affecté, incapable de fonctionner normalement. Un autre symptôme, qui est peut-être le plus manifeste, c'est la douleur que l'on conçoit d'ailleurs facilement en sachant qu'une fracture de côtes porte atteinte aux nerfs intercostaux.

Le dernier symptôme que nous soulignerons est l'emphysème sous-cutané: ce phénomène est dû à une lésion de la plèvre qui livre passage à l'air jusque dans les muscles et les tissus sous-cutanés de la paroi thoracique.

Mais ce n'est pas tout de connaître les symptômes. Comme nous devons aussi être familières avec le traitement, voici celui qui est applicable aux blessures thoraciques. Nos premiers soins seront portés vers le choc que nous devons savoir contrôler. Toutefois, soulignons ici le danger de l'application de chaleur quand on ne dispose pas d'installation voulue pour

une transfusion sanguine immédiate. Car la chaleur, étant vasodilatatrice, activerait la circulation, par conséquent l'hémoptisie.

Comme les complications à craindre concernent surtout la plèvre, il faut appliquer rapidement un pansement occlusif sur la plaie afin d'éviter l'accès de l'air extérieur dans la cavité pleurale.

Au sujet de l'évacuation, vu la gravité des symptômes, ces blessés jouiront de la première priorité.

Et pour terminer, nous jetterons un regard sur *les brûlures*. Nous nous arrêterons, en premier lieu, sur le traitement et les soins immédiats.

Que faut-il faire? Premièrement, combattre le choc quand il existe. Deuxièmement, appliquer un pansement simple et propre sur les régions brûlées en se rappelant qu'un pansement compressif bien fait peut limiter l'exsudat. Il faut aussi couper les vêtements qui gênent la circulation. Prenons garde, toutefois, de n'enlever que le nécessaire car les vêtements peuvent fournir une certaine protection comme isolant. Ensuite, on conseille d'administrer un calmant. Ces blessés, sauf les brûlures légères, seront considérés comme "cas de civière" et jouiront aussi de la première priorité dans l'évacuation.

Après les soins d'urgence, voyons le traitement et les soins ultérieurs: on ne songera pas à instituer un traitement plus complet des brûlures avant que le malade se soit suffisamment rétabli de son état de choc.

Par la suite, l'infirmière a un rôle important à jouer comme auxiliaire du médecin. Quand tout sera prêt pour administrer le traitement secondaire, on découvrira la partie brûlée: les pansements temporaires seront enlevés et les vêtements coupés si on ne peut les retirer sans difficulté ou sans provoquer de la douleur. Comme les vêtements peuvent être souillés ou contaminés, on procédera avec grande minutie afin d'éviter l'infection. Dans le même but, on se gardera d'exposer du même coup une trop grande surface brûlée. On pourra ensuite évaluer l'étendue et le degré de la brûlure. On sait qu'au premier degré, une brûlure ne produit qu'une rougeur de la peau; au deuxième degré, on aura des phlictènes et, au troisième, mortification et destruction de la peau et des tissus sous-jacents. Il faut ensuite administrer la thérapeutique médicamenteuse. Pour lutter contre la déshydratation des tissus, on prescrira ordinairement des solutés alcalins et glucosés. Afin d'abaisser la concentration du sang, on donnera aussi du plasma. Actuellement, on n'a pas encore défini exactement le traitement local. Mais, quel qu'il soit, le but en sera toujours le même: prévenir l'infection, stimuler la meilleure cicatrisation possible, en évitant les scarifications, les formations kéloides, et les contractures.

S'il y a eu aussi lésion par radiations, on en vérifiera l'étendue et ces renseignements seront indiqués sur la fiche du malade.

L'infirmière doit encore surveiller l'ingestion de liquides. Je vous communique donc une règle "pour l'estimation des besoins quotidiens de liquides." Les besoins quotidiens normaux sont évalués à 2,000 ou 3,000 cc. par jour. Les brûlures nécessitent une quantité supplémentaire calculée ainsi:

> Soixante-quinze cc. de sang ou de plasma plus 75 cc. de solution électrolytique (sol. saline) pour chaque 1 pour cent de surface corporelle brûlée. L'addition des besoins normaux et des besoins supplémentaires de l'organisme donnera les besoins quotidiens globaux du malade souffrant de brûlures graves. Et voici maintenant l'ingestion orale proposée en cas d'urgence:
>
> | | |
> |---|---|
> | Eau | 1 gallon |
> | Bicarbonate de sodium | 2 c. à T. |
> | Chlorure de sodium | 3 c. à T. |

Dans les brûlures, la plus grande perte de liquides dans l'organisme se produit pendant les huit premières heures mais elle se continue pendant au moins 48 heures. On administrera donc la solution ci-haut mentionnée au même rythme que dans la perte locale de liquides.

J'ajouterai que l'estimation proposée ici peut varier légèrement avec les auteurs. Si on attache tant d'importance à l'ingestion de liquides, il faut nécessairement exiger le dosage rigoureux des liquides excrétés afin de

pouvoir rapporter tout indice d'oligurie ou de polyurie.

Aux mesures déjà citées pour le soin des brûlures, nous ajouterons le maintien d'une bonne nutrition de l'organisme. L'infirmière, à qui incombe ce devoir, y réussira si elle connaît suffisamment les principes de diététique pour en faire une bonne application.

A elle, revient aussi la responsabilité des soins généraux d'hygiène. Si dans cette tâche elle est assistée d'auxiliaires, elle devra insister, dans sa surveillance, sur les soins particuliers de nettoyage de la peau saine pouvant servir à des prélèvements pour greffes cutanées.

Dans le présent chapitre, on a traité des soins immédiats et ultérieurs ainsi que du traitement des malades souffrant de traumatismes ou de brûlures. On a dû passer sous silence, faute de temps, plusieurs variétés de blessures pouvant survenir dans un désastre atomique. On ne rapporte pas de nouveau genre de blessures attribuables à l'onde de choc et à l'effet calorifique de l'explosion. Les manuels de médecine et de nursing traitent d'une façon détaillés des accidents et des situations d'urgence. Les revues médicales et infirmières nous renseignent, d'autre part, sur les recherches et les découvertes qui peuvent modifier les traitements et les soins préconisés actuellement. Chacune de nous devrait donc faire l'inventaire de ses connaissances et de son habileté professionnelle. S'il y a des lacunes, nous pouvons les combler par des études personnelles, des cours de perfectionnement, et en suivant les programmes d'éducation du personnel.

Nos responsabilités concernant la défense civile dans les situations critiques nous ont été démontrées. On nous a aussi exposé les nombreux problèmes infirmiers qu'il faudrait affronter dans un grand désastre. Certains facteurs, tel l'âge, les handicaps physiques, pourront faire varier la contribution de chacune. Cependant, advenant au Canada un désastre de l'envergure d'une explosion atomique, toutes nous devrions nous considérer moralement tenues de nous mettre à la disposition de notre profession.

Présentement, il importe de se bien préparer, spirituellement et émotivement, à satisfaire à toutes demandes suscitées par un conflit éventuel. L'infirmière doit encore s'habituer à penser clairement, à agir promptement, et à s'adapter facilement aux diverses situations. Afin d'augmenter sa valeur professionnelle, elle doit toujours tenir compté des aspects prévention, psychologie, réadaptation de la maladie en plus de bien connaître les traitements et les soins. En résumé, elle doit s'efforcer d'être l'infirmière idéale.

Le Nursing dans l'Industrie

Une revue américaine—le *Nursing World*—dans le numéro d'octobre publie un article sur les infirmières du Canada en industrie. Trois infirmières—Mlle Jeanne Favreau, Mlle Mildred Walker et Mlle Sarah Wallace—ont contribué à cet article concernant la ligne de conduite à l'égard du personnel; la valeur de la préparation pour l'infirmière en industrie.

L'Afrique du Sud

Lors de la réunion de la division des infirmières en hygiène publique du Collège Royal du Nursing des informations très intéressantes sur le développement du pays furent données par Mlle G. Buttery. Le pays a une superficie de 472,494 milles carrés, la population se compose de deux millions et demi d'Européens et de dix millions de non-Européens. En 1891 la profession d'infirmière était sous l'autorité du gouvernement. Depuis 1944, la profession est dirigée par ses membres. Le Conseil des Infirmières s'occupe des écoles d'infirmières et de l'enregistrement, des infirmières européennes et des autres. Il est obligatoire pour les étudiantes infirmières de faire partie de l'Association des Infirmières de l'Afrique du Sud.

En plus du cours de base, un cours en hygiène publique d'une durée de neuf mois est offert aux infirmières. Les maladies contagieuses qui dominent dans le pays sont la typhoïde, la variole, et la peste.

Trends in Nursing

Report from Saskatchewan

A SPECIAL INSTITUTE was held in November to review the minimum curriculum, theory and practice, presently being followed in Saskatchewan schools of nursing. Directors and faculty representatives from all ten schools attended the institute.

The province is in the fortunate position of receiving more applications for admission to local schools of nursing than can be accommodated and reports that all schools have taken more students in the fall class than can be adequately handled. There has also been increased use of the Dominion-Provincial Youth Training Grant.

The Saskatchewan Registered Nurses' Association, the Saskatchewan Hospital Association, and the provincial government jointly conducted two institutes of two days each late in November especially for the purpose of assisting hospitals, that are not conducting schools of nursing, with their problems. Sections were planned for trustees, hospital administrators, and superintendents of nursing. Time was also devoted to inter-relationships among these groups. The project was financed by the provincial government.

The course in A.B.C. Warfare was given December 11-14. The provincial government paid the expenses of six nurses from the provincial regions, who were prepared to undertake the training of first level nurses in these same regions. Expenses for the six nurses representing schools of nursing, and who will be responsible for the training of the first level groups in areas where there are schools of nursing but where regions have not yet been established, were borne by the Civil Defence Division.

WHO Pilot Survey

Dr. René Sand addressed a conference at the Royal College of Nursing on the pilot study sponsored by the World Health Organization and the Rockefeller Foundation. The study seeks to define the types of health and welfare workers best qualified to meet the various needs of the family with the greatest economy of time, money and "woman power," and the greatest efficiency. Dr. Sand, the director, is a general practitioner, neurologist and pathologist. He is known throughout Europe for his lectures and books on social medicine. The French survey began some months ago and has a large technical advisory committee. Miss Margaret A. Massey, a health visitor, has been appointed to the team working in Luton and Bedfordshire.—*Nursing Times*, Oct. 27, 1951.

Australia

The Federal Government recently created a Federal Division of Nursing to correlate the work being done in the different states. The first principal of this division, Miss F. Peterson, is a nurse with a distinguished war record. One of the states has followed the federal lead and appointed an adviser in nursing. As far as legislation is concerned, the states control nursing. There are six State Acts and six State Registration Boards. In three states, the nursing course is four years and in two other states the course will shortly be extended from three to four years. Approximately 80 per cent of Australian graduate nurses take a midwifery course which takes from six to nine months and in two states has recently been extended to twelve months. Tasmania is the only state providing registration and training for an auxiliary nursing service. Four states are accepting men as nurse trainees. There are two colleges for advanced nursing education—the College of Nursing, Australia, established in 1950, and the New South Wales College. The colleges are not recognized

by the universities but the university authorities have been very helpful in permitting use of lecture rooms, laboratories, etc., and giving the assistance of professional staff. A helicopter, for ambulance work in regions far away from railways or a good road, has been provided for each state by Australia's Department of Civil Aviation.

New Ventures in Nursing Education

1. The Nursing Division of Teachers College, Columbia University, and the hospital administration program of the university's School of Public Health sponsored a conference last month to promote better understanding between hospital executives and nursing service administrators. Seventy students preparing for service in these fields took part in the conference; 14 leaders in these areas served as professional consultants and a team of specialists in conference planning, human relations, and group dynamics also participated. Meetings were supervised by Dr. Kenneth Herrold, associate professor of education in the Guidance Department at Teachers College. The program was financed in part by the Kellogg Foundation. It is thought that this is the first time this integrated educational experience has been offered. It has been made part of the training program because it is known that the way these administrators work together on the job influences the quality of medical service in a modern hospital.

2. Teachers College, Columbia University, has announced that, with the academic year 1951-52, it will give a graduate course in developmental nursing science. The course closely relates the nursing of patients with medical-surgical conditions, degenerative and cardiovascular diseases, cancer and tuberculosis.

The winter session consists of exploring the relationship between the patient's personality and the therapeutic value of better nurse-patient understanding; a person's response to stress and psychosomatic illness and age; and the constitutional factors in illness. The spring session will cover infection and illness, surgery, and changes in living resulting from long-term illness. New courses will also be started in tuberculosis nursing, geriatric nursing, and family-centred nursing.—*The Modern Hospital*, Nov. 1951.

The Head Nurse and Her Time

The Massachusetts General Hospital, concerned with the load carried by the head nurse, requested assistance from the Division of Nursing Resources, USPHS, for "an analysis of the head nurse functions to see what could be done either by reallocation of duties or by adding personnel to the ward staff to reduce the demands made upon her." The request was finally broken down as follows:

1. What are the head nurses now doing?
2. Could any of these things be done by other staff members?
3. How much time does the head nurse spend on each of her responsibilities?
4. What proportion of her time is spent on duties that do not require head nurse skill?
5. How much additional time would be needed for any other category of personnel to perform these duties?

The results of the study have now been published in *The Modern Hospital*, Nov. 1951. Briefly, they showed that the head nurse was spending more than 50 per cent of her time on patient care, education, and assignment of patient care. The analysis of functions for reallocation indicated that 33 per cent of the present head nurse functions could be performed by other personnel in spite of the fact that four of the five units already had clerks. Sixty-seven per cent of her time, it was found, was spent in tasks that require head nurse skills and decisions. A further analysis indicated areas in which, if time were available, the head nurse could carry out functions she does not now have sufficient time to perform adequately. These are chiefly staff assignments, planning

with the staff for patient care, staff and student teaching.

It was, therefore, shown that before the head nurse could assume any more responsibility of staff supervision, patient teaching or other areas, certain present responsibilities will have to be delegated to other classes of personnel. Fifty per cent of the time spent in management was found to be reassignable to a clerk; others to whom activities could have been reassigned were the professional and non-professional personnel and personnel of other departments. It was also shown that the head nurse had many interruptions that were unavoidable and which interfered with the performance of activities which required concentration.

Study of the more detailed report, with accompanying tables, will be of interest to many. Those who wish further details should secure the monograph "A Study of Head Nurse Functions in a General Hospital" to be published by the U.S. Public Health Service.

Round Table on Nurse Education

The Modern Hospital periodically invites several administrators to the editorial office to discuss their problems. A recording of the conversation is made and the transcript, after elimination of repetition, is published. Their November issue carries a report of the most recent discussion "Where Should Nursing Education Begin and End?" The discussion revolved around the cost of nursing service. The assumption was made that without nursing schools and nursing education there would not be any nursing service and this led to the discussion of the cost of nursing education. Following much discussion on how to evaluate the service rendered by the student and graduate, Mr. Ralph M. Hueston, administrator of Wesley Hospital, Chicago, volunteered the information that their present resident in hospital administration was making a cost study of nursing education.

Other questions raised were the relative quality of nursing care given by student and graduate general duty nurse; the year in which student gave the greatest amount of service to the hospital; whether too much stress was being put upon the faculty member's possession of a degree rather than her abilities as a person and teacher; how to evaluate the quality of teaching; accreditation of schools of nursing; admission standards; critical attitude of high school students; how to conserve for nursing, applicants not able to meet admission standards; applicant's inability to meet cost; the central school of nursing; personal care for patients; need for special training for head nurses and in-service education. No decisions were reached but the discussion pointed up many problems, none of them new but all, because of present stresses, calling for serious thought and considered action.

Study at Harper

One of the results of the recent study made at Harper Hospital, Detroit, was to point up that the professional nurse on the 7 to 3 shift spent 65.9 per cent of her time on direct bedside care. From 3 to 11, she spent 48 per cent of her time on direct bedside care. From 11 to 7, the percentage dropped to 30.8 per cent. One of the significant factors of the activity studies was that graphs made of the peak periods during 24 hours showed that hospital routines should be examined more thoroughly. It was found that while many orders were carried out at the same hour, it was the interval in their timing rather than the definite hour at which they were performed that was important. It is suggested that once known, peak periods could be "smoothed off" by proper planning thus allowing for better staffing.—*R.N.*, Nov. 1951.

Hospital Administration

A series of workshops dealing with hospital administration and its problems and giving special attention to small hospitals will be held by the

Catholic Hospital Association in several centres. In these workshops, the principle of *better administration for better care of the patient* will be the keynote. An editorial in the October *Hospital Progress* states that "the heart and soul of a hospital is nursing service." The article then comments on how the hospital might learn from industry techniques that would assure a better job of giving complete and personal attention to the patient with fewer people; that it is not enough for personnel policies to promote harmony between employees and management but that they must embrace the objective of the institution and promote the welfare of the sick in hospital. This article ends on the note that—

> Despite lofty ideals and high sounding objectives, the patient and his convenience are frequently subordinated to the sacredness of certain arbitrary administrative practices or customs which have been instituted to serve secondary objectives rather than the primary objectives of the institution.

In this series of workshops "improved administration will be emphasized as a means of improving the care of the patient."

Cause of Nurse Shortage

Licensed nurses must be freed from non-nursing duties if the nursing shortage is to be eased, reported Clara Quereau, secretary of the Board of Examiners of Nurses of the New York State Education Department—

> From 35 to 50 per cent of the time of licensed nurses is spent in carrying out non-nursing duties.

—*Hospitals*, Nov. 1951.

Psychology for Nurses

In a recent article in *Nursing Times* (Sept. 22, 1951), "Reactions to Illness," Dr. A. T. M. Wilson of the Tavistock Institute of Human Relations enlarged upon common and special factors influencing attitudes toward illness, common patterns of reactions, and practical points to be remembered in applying knowledge to the everyday care of patients. He makes the point that introducing "psychology" into the nursing curriculum rather than making the nurse the proud possessor of a special body of knowledge should make her more aware of the problems of people in general; of the problems of patients, their relatives, doctors, nurses, and of herself:

> From most points of view human beings are much more alike than they are different whether they are sick or well, or whether they are patients, nurses, or doctors; and the first essential of an approach to nursing, which includes recognition of psychological aspects of illness and recovery, is the acceptance of this basic fact. In their response to the illness, the treatment, and to other human beings, patients do not essentially differ from those professionally engaged in helping them to recover.

To the criticism that doctors and nurses are often difficult patients, he offers the suggestion that they probably are better informed of the risks involved and that as patients—

> They feel more keenly the inadequacy of much present-day work in paying more than lip service to the fact that patients are people, with all the hopes and fears which all of us share in and out of illness.

Speaking of depression Dr. Wilson claims that not to recognize the patient's need to mourn under certain circumstances is not to face reality and that—

> Permission to "mourn," not given in words but by one's attitude, may be a major factor in initiating recovery from such a phase of illness.

Statisticians say that two out of every five diabetics are unaware that they have the disease. To be sure that there is no possibility of the disease becoming established, it is wise to have regular medical check-ups, in which tests for the disease will be given. Those who are overweight and over 40 should be particularly alert for any symptom of diabetes.

Orientation et Tendances en Nursing

Un Rapport de la Saskatchewan

Des journées d'études eurent lieu en novembre dans le but de reviser le programme d'étude minimum, théorique et pratique, suivi par les écoles d'infirmières de cette province. Les directrices et des représentantes des facultés des dix écoles assistèrent à ces journées d'études.

Dans cette province, les écoles sont dans l'agréable situation de recevoir plus de demande d'admission qu'elles peuvent admettre d'étudiantes. Dans toutes les écoles l'on a admis plus d'étudiantes à l'entrée de septembre que le nombre prévu. L'on attribue cette augmentation aux prêts-bourses de l'Aide à la Jeunesse d'après l'entente fédérale-provinciale.

Dans le but d'étudier les problèmes des hôpitaux n'ayant pas d'écoles d'infirmières, deux cercles d'études formés de l'Association des Infirmières, l'Association des Hôpitaux, et du gouvernement de la Saskatchewan tinrent conjointement deux réunions de deux jours chacune. Divers groupes furent formés —celui des administrateurs, des directeurs, et des directrices du nursing. L'on consacra suffisamment de temps à l'étude des relations interdépartementales. Le gouvernement provincial se chargea des dépenses de ce congrès.

Le cours sur les Aspects du Nursing dans la Guerre A.B.C. fut donné du 11 au 14 décembre. Le gouvernement provincial paya les dépenses de six infirmières lesquelles prépareront par la suite d'autres infirmières. La Division de la Défense Civile de la province se chargea des dépenses de six infirmières représentant les écoles d'infirmières, lesquelles devront également donner ces cours dans les régions où elles se trouvent.

Le Relevé-Guide de l'O.M.S.

Le Dr René Sand donna une conférence au Collège Royal du Nursing à Londres sur l'étude devant être faite sous les auspices de l'O.M.S. et la Fondation Rockefeller.

Le but de cette étude est de définir quelles personnes au point de vue santé et bien-être sont les mieux qualifiées pour répondre aux besoins de la famille et ce avec la plus grande économie de temps, d'argent, et de la main-d'oeuvre féminine (woman power) et avec toute la compétence voulue. Le Dr Sand, le directeur, est en praticien, neurologiste et pathologiste. Il est bien connu en Europe par ses conférences et ses livres sur la médecine sociale. Le relevé en France fut commencé il y a quelques mois et un comité, composé d'un grand nombre de conseillers techniques, a été nommé à cet effet.—*Nursing Times*, oct. 27, 1951.

Nouvelles Tentatives en Nursing

La division du nursing du Teachers College, Columbia University, et la division de l'administration des hôpitaux de l'Ecole de l'Hygiène Publique de la même université se réunirent en conférence récemment pour promouvoir une meilleure entente entre les administrateurs d'hôpitaux et les directrices des services du nursing. Soixante-dix étudiants, se préparant à l'un de ces services respectifs, assistèrent à cette conférence. Quatorze personnes, bien qualifiées dans ces domaines, agirent comme consultants. La préparation des conférences au personnel, les relations, etc., furent confiés à un groupe de spécialistes. Ce programme était sous les auspices de la Fondation Kellogg. Cette conférence a été mise au programme du cours régulier, étant donné que les relations entre ces diverses administrateurs ont une grande influence sur la qualité du service aux malades dans l'hôpital moderne.

Au Teachers College, Columbia University, un nouveau cours sera donné durant l'année académique 1951-52. Durant ce cours l'on étudiera le développement de la science en nursing par rapport aux soins à donner dans certains cas de médecine, de chirurgie, de dégénérescence, de maladies cardiovasculaires, de cancer, et de tuberculose.

La valeur thérapeutique d'une meilleure compréhension entre l'infirmière et le malade, la réaction d'une personne soumise à un trop gros effort, la médecine psychosomatique, l'âge et les autres facteurs causant la maladie seront étudiés durant les cours de l'automne. A la session du printemps, les cours porteront sur l'infection et la maladie, la chirurgie, et les changements qu'apportent dans la manière de vivre les maladies chroniques. Des cours seront aussi donnés sur le nursing en tuberculose, le nursing chez les vieillards et sur les répercussions de la maladie sur la famille.

L'Hospitalière et l'Emploi de Son Temps

Une étude très intéressante a été faite à l'Hôpital Général de Massachusetts consi-

dérant l'énorme somme de travail de l'hospitalière. L'on se demanda comment l'on pourrait diminuer sa tâche. Devrait-on confier à d'autres personnes quelques-unes de ses attributions ou devrait-on augmenter le personnel? Une analyse du travail de l'hospitalière a été faite et l'on a répondu aux questions suivantes: (1) Quel est le travail de l'hospitalière? (2) Une partie de son travail peut-il être fait par d'autres membres du personnel? (3) Combien de temps l'hospitalière emploie-t-elle à l'accomplissement de chacune de ses tâches? (4) Quelle partie de son travail ne requiert pas la formation qu'elle a reçue? (5) Combien de temps supplémentaire faudrait-il à d'autres personnes pour accomplir ces tâches?

Le résultat de l'étude (voir *The Modern Hospital*, nov. 1951) est le suivant: L'hospitalière consacre plus que 50 pour cent de son temps au soin des malades, à l'enseignement et à la direction des soins des malades. L'analyse des tâches révèle que 33 pour cent du travail de l'hospitalière pourrait être accompli par d'autres membres du personnel. Soixante-sept pour cent de son temps est employé à un travail qui demande à la fois la formation et l'expérience d'une hospitalière. Une secrétaire semble la personne toute indiquée pour se charger d'une certaine partie du travail sur l'étage. Les nombreuses interruptions inévitables semblent une des causes nuisant le plus à l'hospitalière dans son travail et dans la réflexion qu'elle doit y apporter.

Le détail de cette étude sera publié sous le titre de "A Study of Head Nurse Functions in a General Hospital" par le U.S. Public Health Service.

Discussion

La revue *The Modern Hospital* invite périodiquement plusieurs administrateurs à venir discuter de leurs problèmes. L'on enregistre la conversation que l'on publie après en avoir éliminé les répétitions. Le numéro de novembre publie une de ces conversations intitulée "Quand Commence et Quand se Termine l'Education de l'Infirmière?" La discussion parla sur le coût des services du nursing. L'opinion prévalente fut que sans école d'infirmières et sans éducation en nursing, il n'y aurait de service du nursing.

Un administrateur du Wesley Hospital de Chicago, M. R.-M. Hueston, révéla qu'une étude était présentement faite à cet hôpital sur le coût de l'éducation de l'infirmière. D'autres questions très intéressantes furent discutées, tel que la qualité des soins donnés par les étudiantes et par les infirmières en service général; l'année de leur cours durant laquelle les étudiantes donnent le plus grand rendement ou le plus de service à l'hôpital; devrait-on appuyer autant sur les qualifications académiques ou davantage sur l'habilité de l'institutrice à l'enseignement; comment évaluer la qualité de l'enseignement; accréditation des écoles d'infirmières; les normes de l'admission à l'étude; l'attitude des étudiantes des écoles primaires supérieures.

Etude Intéressante

Une étude récente faite au Harper Hospital, Detroit, révèle que l'infirmière professionnelle, travaillant de 7:00 à 3:00 p.m., emploie 65.9 pour cent de son temps directement aux soins des malades; de 3:00 à 11:00 p.m., 48 pour cent directement aux soins des malades, mais celle qui travaille 11:00 p.m. à 7:00 a.m. n'emploie que 30.8 pour cent de son temps en soins directs. Il ressort de cette étude qu'une partie du travail de routine pourrait être mieux réparti.

L'Australie

Le gouvernement fédéral de ce pays vient de former une division du nursing pour coordonner le travail fait dans les différents états. La première directrice de cette division est Mlle F. Peterson, une infirmière bien qualifiée, ayant eu l'expérience de la guerre. Un des états a suivi l'exemple du gouvernement fédéral et a nommé une consultante en nursing. La profession, au point de vue légal, est sous l'autorité de l'état. L'Australie est divisée en six états et chaque état a sa propre loi concernant les infirmières. La durée du cours, dans trois états, est de quatre ans et dans deux autres états le cours de trois ans sera prolongé d'une autre année. Environ 80 pour cent des infirmières suivent en plus un cours de sage-femme dont la durée varie de six à neuf mois. Dans deux états ce cours est de douze mois. Dans l'état de Tasmanie un cours pour personnel infirmier auxiliaire donne droit à un enregistrement.

Dans quatre états les hommes sont acceptés comme étudiants dans les écoles d'infirmières. Deux collèges, ou écoles supérieures pour infirmières, sont établis au pays. Ces collèges ne sont pas reconnus par les universités mais les autorités universitaires mettent à la disposition aux collèges, des salles, des laboratoires, et des professeurs de l'université

y font de l'enseignement. Un hélicoptère a été mis à la disposition de chaque état par le Département de l'Aviation Civile de l'Australie pour le service d'ambulance dans les régions éloignées des chemins de fer et ne possédant pas de route.

Administration d'Hôpitaux

L'Association des Hôpitaux Catholiques tiendra des journées d'études à plusieurs endroits des Etats-Unis afin d'étudier les problèmes des petits hôpitaux. Le thème de ces journées d'étude est *une meilleure administration en vue de meilleurs soins aux malades.*

Dans le numéro d'octobre de *Hospital Progress* l'article éditorial définit "le service du nursing comme le coeur et l'âme de l'hôpital." L'on recommande d'étudier les méthodes de l'industrie afin de faire un meilleur travail et donner une attention plus complète à chaque malade. Bonnes relations entre employeurs et employés ne sont pas suffisantes. Chacun devrait travailler à atteindre le but de l'hôpital et aider à assurer le bien-être des malades à l'hôpital.

La Psychologie et les Infirmières

Cette matière devrait être au programme d'étude dans toutes les écoles d'infirmières recommande le Dr A. T. M. Wilson dans un article publié dans le *Nursing Times* (sept. 22, 1951) et intitulé "Réactions à la Maladie." Les infirmières devraient mieux comprendre le problème de la maladie, les réactions de la famille, etc. Les gens se ressemblent et réagissent souvent de la même façon en santé ou en maladie. L'infirmière devrait connaître les réactions des malades durant leur maladie, la convalescence, etc.

L'on se plaint souvent que les médecins et les infirmières ne sont pas de bons malades. C'est souvent dû au fait que leurs connaissances leur permettent de juger mieux de la gravité des risques et les bonnes paroles auront peu d'effet sur leurs espérances ou leurs craintes. Il faut comprendre le malade et le considérer comme une personne.

Des Plus Modernes!

Dans un hôpital de Suède une étudiante-infirmière anglaise, bénéficiant d'une bourse d'étude, rapporte que dans l'hôpital neurologique de Serafimer des bicyclettes sont à la disposition du personnel pour circuler à travers les longs corridors de l'institution.—*Nursing Times*, nov. 3, 1951.

Annual Meeting in Prince Edward Island

The 30th annual meeting of the Association of Nurses of Prince Edward Island was held on October 2, 1951, in Summerside, with a total registration of 81 members. The president, Sister Mary Stanislaus, was in the chair.

In her address, the president welcomed all new members to the association and to the meeting. She gave a special welcome to Miss Gertrude Hall, general secretary-treasurer of the Canadian Nurses' Association, and expressed the pleasure of the members in having her attend the annual meeting and speak to us.

The president recalled briefly the past when the association had a small membership and, consequently, inadequate financial resources. In comparing the past with our present situation, she asked us to stop and question if, in the light of our better circumstances, we were doing more to fulfil the aims of nursing as set down by the parent association. While we have made advances to our credit, there are a number of problems still needing attention—affiliation for our schools of nursing in tuberculosis, psychiatry, and public health; more and diverse educational programs for the members of the association with greater participation by the members; the need for study of the role of the nursing assistant in the nursing team and for understanding and accepting our responsibilities in helping this group, also, to serve the community. She urged that we show as much interest in our nursing *Journal* as we do in the latest fashions or best-sellers as, price for price, the returns from the latter do not merit comparison. In closing, the president paid tribute to the memory of Mrs. Ina Beer—a past president of this association and a valued and esteemed member whose loss will be deeply felt by all who knew and worked with her.

The report of the secretary-registrar gave a résumé on matters of importance to nursing

in Prince Edward Island and the work done during the past year. A request was made by Summerside that a chapter of the association might be formed. This will automatically divide the association into two regions. It is a move long overdue and is considered to be a step forward. Miss Helen Schurman, superintendent of Prince County Hospital, was appointed chairman and asked to organize the chapter.

Registration figures for the first nine months of the year, to September 30, 1951:

Practising membership	313
Non-practising membership	128
Non-resident: practising	42
non-practising	17

The chairman of the Institutional Nursing Committee, Sister John Baptist, reported on the series of educational programs held during the winter months. This included: a typical hospital staff conference entitled "One Way of Doing It"; a dramatized discussion of purely nursing problems; a talk and discussion on "Methods of Clinical Teaching," followed by a conference on diabetes mellitus by staff and students after an interview with the patient; poliomyelitis—signs, symptoms, treatment, and nursing care; geriatrics—introduction to the subject and question period.

Miss Ruth Ross, chairman of the Public Health Nursing Committee, reviewed the series of four meetings on "Newer Trends in Nutrition." Nurses from all sections were invited to attend.

Sister Mary Irene presented the report of the Committee on Legislation, which included the revisions necessary in the by-laws for the setting up of two chapters.

The two chapters will be:

1. *Charlottetown*, to include Queen's and King's counties.
2. *Summerside*, covering Prince County.

Following the report on *The Canadian Nurse*, discussion dealt with the low percentage of graduate nurses who subscribe to their *Journal*. The result of the discussion was a motion that the annual fee as a practising member be $8.00 instead of $5.00 and that this fee include a yearly subscription to *The Canadian Nurse*. A standing vote was taken and it was passed unanimously.

During the course of the meeting, the president brought to the attention of the members, Miss Anna Mair's 25th anniversary as superintendent of the Prince Edward Island Hospital. Tribute was paid to her valued years of service and strong support in the Association of Nurses of Prince Edward Island and a resolution passed that a letter and token of our appreciation be sent to her.

The guest speaker in the afternoon was Miss Hall. Her address, "Looking Ahead with the Nursing Profession," was stimulating and thought-provoking. The evening preceding the annual meeting, Miss Hall spoke in Summerside and again the day following in Charlottetown on "The Central School." The groups included nurses, doctors, and selected lay people, either directly or indirectly interested in schools of nursing. Miss Hall was heard with deep interest and the response was most gratifying.

Dr. J. B. Downing was guest speaker at the dinner. His address on "Cortisone" gave, in detail, the advantages and disadvantages of the drug, when it may and may not be used, and other factual material concerning it.

The following are the officers for the coming year: President, Sister Mary Stanislaus; first vice-president, Miss Verna Darrach; second vice-president, Miss Helen Schurman; honorary treasurer, Miss Ida MacKay; honorary secretary, Mrs. Mary Maddigan.

MURIEL ARCHIBALD
Secretary-Registrar

Study Tour In Britain

Nurses contemplating a trip to Britain next summer may be interested in the Pediatric Study Tour being sponsored by the National Council of Nurses of Great Britain and Northern Ireland. Commencing in London on June 29, 1952, the course will be concluded on July 9. The fee for the course will be £12/10, which will include room and board and the cost of trips on sight-seeing visits.

The main theme of the study tour will be pediatrics in the widest sense, covering the welfare of children up to the age of 15 years. Enrolment for the course is to be limited to 36 nurses. Canadians wishing to participate should make immediate application through the *Canadian Nurses' Association, Suite 401, 1411 Crescent St., Montreal 25, Que.* The closing date for applications is *March 1, 1952*.

Proposed Action Program for Civil Defence Casualty Services

THE WORKING PARTY on Casualty Services, at a meeting held in Ottawa on November 12, 1951, recommended certain steps as a means for translating paper planning into early and energetic action. The committee emphasized the need for uniform action across the country in order to avoid gaps in the support program. This is essential in Canada as shortages in professional personnel and essential facilities, such as hospitals, will make it necessary to arrange for assistance from communities which may be many miles from the disaster area. In suggesting a first phase objective for the country as a whole, and a breakdown for individual provinces, it is appreciated that the figures are tentative and can only be finalized after discussion with the Civil Defence Health Service planners in each of the provinces. The first phase action program for Civil Defence Casualty Services in Canada, as recommended by the Working Party, is as follows:

1. The Working Party stressed the need for the immediate appointment of the following for target and mutual aid areas (see Civil Defence Health Services Manual, *Fig. B.3*):

(a) *Director of Civil Defence Health Services.*

(b) *Advisory Council*—with representatives from professional associations, voluntary agencies, and governmental groups in the community concerned with health.

(c) *Assistant Directors of Branch Services.*

It was appreciated that in many cases these appointments had already been made but certain key areas had not as yet carried out this important preliminary step. In particular, the importance of the Advisory Council was stressed as a means of obtaining the support and active co-operation of professional and voluntary groups.

2. When the appointments mentioned in *No. 1* had been completed it was recommended that regional meetings be held to allow local, provincial, and federal health services planners to discuss problems of mutual interest.

3. (a) Target and mutual aid areas should prepare a careful inventory of all local resources of personnel, facilities, and equipment. When these resources have been carefully assessed it would be possible to determine the additional assistance required from more distant communities.

(b) In order to assist with this assessment it was recommended that provincial and local organizations be supplied with information regarding physicians, dentists, and pharmacists available from registers kept by national organizations and by departments of government. Consideration is also being given to an inventory of nursing resources in Canada.

(c) It was stressed that Civil Defence Health Service planners should avoid, as far as possible, recruiting persons of military age or members of the reserve forces for key positions in the Civil Defence Health Service Organization.

4. (a) The members of the Working Party considered it essential that in order to ensure uniformity of action and rapid progress in the development of health service plans in target and mutual aid areas, small full-time units be employed in larger target areas and part-time units in smaller. The establishment in each case would depend on the size and importance of the target area. For example, in the larger centres, it would probably consist of a physician, nursing consultant, and necessary clerical staff.

(b) The Working Party also considered that similar units would be required at provincial level to coordinate plans within the province.

5. *First Aid Stations*

(a) It was recommended, as a first phase development, that a minimum of 150 first aid stations be established across

Canada and that these units be organized and personnel trained to operational level as quickly as possible.

(b) A tentative provincial breakdown of the figure suggested in 5(*a*) can be estimated roughly on the number and importance of the target areas in a province and the strategic location of certain other communities as immediate support areas. However, other variables will occur and these tentative figures can only be finalized after discussion with provincial planners.

(c) The Working Party accepted the staffing pattern for First Aid Stations set out in the Civil Defence Health Services Manual, Sec. D, page 8. It recommended also that reserves of personnel be provided to allow for casualties. The casualty factor recommended was one-half in the case of professional personnel and one-third for non-professional groups. The lower casualty factor for non-professional persons was suggested as it was considered practical in most cases to recruit personnel for this group from the periphery or outside the potential target.

(d) First aid supplies required for training—the Working Party recommended that training kits be provided for each first aid station formed and that the Civil Defence Health Planning group work out the items and quantities required for training. Details are attached as *Appendix A* to this memorandum.

(e) Supplies for first aid stations—the Working Party accepted the item listed in Civil Defence Health Services Manual, Sec. D, pages 9-11. It recommended the immediate procurement of such supplies in quantities sufficient to meet the requirements of the number of first aid stations to be established. They further recommended the storage of such supplies at regional bases with local storage when the state of emergency indicated this further distribution.

6. *Hospitals*

(a) *Existing hospitals of all types:*

(i) It was recommended that detailed emergency plans be prepared for all existing hospitals in target and mutual aid areas with a population of over 50,000. These plans should include the allocation of staff for emergency duties.

(ii) It was further recommended that similar detailed emergency plans be prepared for existing hospitals in reception and mobile support communities which are located at points suitable for use as base hospital units.

In order to assist with the detailed planning and to ensure that the results are comparable, a hospital sub-committee is preparing a standard hospital planning survey kit.

(b) *Improvised hospitals:*

(i) It was recommended that detailed emergency plans be prepared for buildings considered suitable for use as improvised hospitals in target and mutual aid areas, also in cities with a population of over 50,000. These plans should include the allocation of staff to these emergency units.

(ii) It was suggested also that the survey of local resources be carried out by survey teams consisting of a hospital administrator, a nursing consultant, and an experienced surgeon.

(c) *Additional professional personnel* required to staff emergency hospital units:

(i) Affiliated units of physicians for hospital services—The Working Party accepted the details set out in the Civil Defence Health Services Manual, Sec. E.2, pages 9-11. It recommended that these units be set up as quickly as possible and in sufficient number to provide adequate assistance for the potential target areas. The actual number to be established in each province could be determined after discussion with provincial Civil Defence Health planners.

(ii) The Working Party also stressed the need for specialist teams but considered that more information should be obtained on the type of specialist service required. The Civil Defence Health Planning Group is to obtain this information and it will form part of the advice issued for subsequent casualty service development.

(d) *Hospital supplies:*

The itemized list of essential medical supplies, appearing in the Civil Defence Health Services Manual as *Appendix B. 1*, was accepted by the Working Party. It was recommended that steps be taken immediately, as a part of this first phase program, towards the procurement of sufficient of the supplies listed as would meet the requirements of at least 50,000 casualties. It was further recommended that such supplies be stored at regional centres at locations which are readily accessible to potential target areas.

7. *Casualty service transportation*

(a) It was recommended that local Civil Defence Health Service planners arrange with the transportation services of their civil defence organization to have vehicles allocated to service the various casualty service units and on a scale consistent with the ambulance services section of the Civil Defence Health Services Manual, Sec. D, pages 12-13.

(b) Such local planners were also reminded of the need for detailed planning of transportation to and from more distant points and that these details should be arranged in consultation with the provincial authorities.

(c) The Working Party also recommended that the advice of the Federal Civil Defence Transportation Committee be obtained on these long distance transportation problems.

8. *Casualty service communication arrangements*

A similar approach to that adopted for transportation arrangements was recommended for communications.

9. *Steps recommended to assure energetic action*

(a) It was recommended that the details of this suggested action program be submitted to the Dominion Council of Health for its consideration and support.

(b) It was further recommended that the Minister of National Health and Welfare be asked to inform the Provincial Ministers, responsible for civil defence, of the details of this action program and request that such Ministers do their utmost to see that the program is carried out in their provinces. Also, that the Minister of National Health and Welfare be asked to write to the national professional associations giving them the details of the programs and urging their active support.

(c) It was also suggested that a member of the Federal Civil Defence Health Planning Group visit each of the provinces in the immediate future to discuss the details of the action program with provincial Civil Defence Health planners.

10. *Objective deadline*

The Working Party for Casualty Services recommended that June 30, 1952, be regarded as the date by which all action required to implement this first phase program be completed.

Appendix A

SUPPLIES AND EQUIPMENT REQUIRED

One unit as listed below should be provided for training purposes for each First Aid Station.

Item	*Amount*
Stretchers	4
Blankets	8
Instrument set, 1, each containing:	
Scissors, surgical, Mayo 5½", straight	1
Scissors, surgical, Mayo 5½", curved	1
Forceps, hemostatic, curved	12
Forceps, hemostatic, straight	12
Forceps, tissue, smooth, 5½"	1
Forceps, tissue, rat-toothed, 5½"	1
Needle driver	1
Retractor, general operating, nested, one 8¼", one 8½", set	1
Handles, knife No. 3	1
Blades, No. 10.....package 6	
Tube, breathing (airway), hard rubber or metal (adult)	1
Tube, breathing (airway), hard rubber or metal (child)	1
Tube, tracheotomy, large, (adult)	1
Tube, tracheotomy, (child)	1
Scissors, bandage	6
Dressing, first aid, large military type	24
Bandages, gauze, 4" x 6 yd. with woven edge	24
Cellulose dressing, gauze facing, medium size, first aid treatment of burns	24
Cellulose dressing, gauze facing, large size, first aid treatment of burns	12
Bandages, tensile, (for cellulose dressing), 3"	12
Bandages, tensile, (for cellulose dressing), 6"	12
Bandages, triangular muslin, 52 x 37 x 37"	6

Cotton waste, pounds	12	Pencils, skin	3
Pins, safety, large, package 12's	6	Razor blades, package of 10	1
Splints, sets	6	Razor blade holders	3
Pencils, indelible	3	Basins, 9 x 6 x 1⅞"	1
Tourniquet	1	Splints, Thomas, complete	6
Tags, emergency medical, book of 20's	5	Splints, Kramer, 3½ x 31"	2
First Aid Station log book	1	Splints, Kramer, 3½ x 15½'	2

In Memoriam

Harriette (Seeley) Bassler, who received her professional training in Kingston, Ont., died in New York on December 14, 1951, at the age of 61.

* * *

Henrietta Beaudoin, a student nurse at the Vegreville Hospital, Alta., was instantly killed in a fall downstairs in November, 1951. She was 19 years of age.

* * *

Eileen Marie Crowley, who graduated from St. Mary's Hospital, Kitchener, died in London, Ont., in November, 1951, following a lengthy illness.

* * *

Ethleen (Greer) Eamer, who graduated from St. Luke's General Hospital, Ottawa, in 1911, died on October 2, 1951.

* * *

Helen Winnifred Holmes, who graduated from Wellesley Hospital, Toronto, in 1925, died in Toronto on December 11, 1951.

* * *

Grace (Grant) Hopper, who graduated from the Moncton Hospital, N.B., in 1922, died in Moncton in December, 1951, after a short illness. Prior to her marriage, Mrs. Hopper was on the staff of the Massachusetts General Hospital, Boston. At the time of her death she was in charge of the Nurses' Registry for the Moncton Hospital.

* * *

Christina C. Kerr, a graduate of the Hamilton General Hospital, Ont., died in Hamilton following serious injuries received when she was struck by an automobile on December 8, 1951.

* * *

Madeleine Lagarde, a preliminary student at Ste. Justine's Hospital, Montreal, was killed in a motor accident in Montreal in December, 1951.

* * *

Hester Kathrine Mackay, who was one of the seven nurses who organized the Alberta Association of Registered Nurses, died in England last autumn. Trained in Britain, Miss Mackay went to Calgary to work in 1911. She returned to England when World War I broke out and served in France with the Imperial Forces. She returned to Canada and entered the field of public health nursing. She went to California where she was active as a county public health nurse for many years prior to her retirement in 1943. She then lived in Edmonton until her return to England in 1949.

* * *

Marielle Potvin, a first-year student nurse at St. Vincent de Paul Hospital, Sherbrooke, Que., died from injuries sustained when she was struck by an automobile on November 15, 1951. Miss Potvin was 21.

* * *

Isabel (Manson) Prince, who was in charge of the courses in public health nursing at the McGill School for Graduate Nurses from 1929 to 1933, died in Boston, Mass., on August 27, 1951, following a lengthy illness. Born in Saskatchewan, Mrs. Prince obtained her B.A. degree from the university in that province before entering nursing. She graduated from Presbyterian Hospital, New York, in 1925. She then joined the staff of the Victorian Order of Nurses in Winnipeg. Receiving a V.O.N. scholarship later, she enrolled for the public health course given by the League of Red Cross Societies at Bedford College, London, Eng. On her return to Canada she was appointed as an assistant teacher and supervisor with the Victorian Order of Nurses in Montreal. Her appointment to the McGill School broadened her opportunities to teach.

* * *

Jean Frances (Botting) Todd died in Toronto on November 6, 1951, at the age of 74. Some years ago Mrs. Todd was superintendent of nurses at the Sarnia General Hospital, Ont.

Student Nurses

Adjustments — Wise and Otherwise!

Note: Following a series of lectures in Professional Adjustment I, each probationer in one of our schools of nursing was asked to write an essay regarding the various adjustments which she had found it advantageous to make since her entrance into the school. The following illuminating comments may make some of us older nurses pause and think. How do our own professional adjustments measure up?

In the past six weeks I have knowingly changed my habits of living more than in any other six weeks of my whole 18 years! For one thing, I have mentally absorbed more knowledge in this six weeks than I generally have done in 10 months in any school year. I believe I have made my greatest change in regard to my attitude in class. Some of my old teachers would not recognize the girl who slept or dawdled through each class.

It was a revelation to me to learn that 15 or 20 minutes is all that one should study on any subject at any one time. Also that one should rest one's mind for a few minutes before beginning to study another subject. It is surprising how well this works! I have also learned recently, from my own experience, that if I study shortly after I have had a sleep I remember that work much better.

My health is safeguarded a lot more here. If I were at home I don't think I would have gone to the doctor for all those immunizing shots! Painful, but I survived! I am glad I am protected from so many diseases now.

Getting into my uniform seemed, at first, a hopeless task which I, alone, would never accomplish. After a few days I decided it was a little ridiculous to have my Big Sister practically dress me every morning. Back in my school days, I was accustomed to a change of styles throughout the week, but now—just give me the blue and white!

I used to think that 7:00 was an early hour to rise, but now!—6:15 a.m. —ugh! Getting up with an alarm clock is so different from hearing Mother call: "It is time to get up!" Of course, I always took it for granted that she called me too early, so I usually turned over and had another little sleep while waiting for the second call. Second calls here, I find, are pretty embarrassing! So I have to set the alarm and put it over near the door so that I will have to get up to turn it off when it starts ringing in, what I consider, the middle of the night. What price—a profession!

Morning prayers have always been a headache to me because I never could remember to say them, but now it seems that I understand better why I should pray and I manage to get a prayer or two in while dressing—it isn't as hard as I thought and it makes me feel good to start the day right.

We lived six miles from church at home so it is nice to have the opportunity of slipping into the chapel whenever I feel like saying "hello" to God and telling Him all the things that happen to me during the day. Of course He knows them already, just like at home Dad used to know most of the things that happened to me. But I think God is just as interested in me telling Him about my thoughts and ideas as Dad was, when we used to talk over things at home. After all, God is our Father.

I'll have to get used to meeting people easily since it is an everyday occurrence here. I am trying to get out of the habit of dropping my eyes when meeting anyone. So far, I have managed to get my eyes up as far as their chins. Perhaps I'll soon be able to look right at them and "smile graciously"!

Mealtime has become more or less a matter of routine. I do not look forward to my meals as enthusiastically as I did before I came. I am not suggesting that previously I lived to eat and now that I merely eat to live. Nevertheless, the systematic organization of meals is so different from the free and easy way of eating at home. Sometimes I am really hungry but when I get to the dining-room I can't eat. It could be excitement or nervousness or something. However, I am slowly adjusting to eating cafeteria style and also to not having to wash the dishes after the meals—nice adjustment, that!

The one thing I miss most is not having men and a dog around the place. At home, all the men would gather around Dad and I would sit and listen to them talk for hours about guns, hunting, and the like. Some of the men were like second fathers to me. I learned woodcarving from one and all I know about entomology from another. Now my surroundings are so decidedly feminine and my companions so decidedly female that I sometimes feel like skipping off to a stag party. I would love to have a dog here and I still feel that an establishment housing so many helpless women should have a good watchdog.

The adjustment I have found pleasantest to make is that of living in residence. I think that having a room of my own makes this easy because when I get fed up I can always go there and be alone. Fortunately, the need does not arise very often. Although I cannot as yet form an opinion of some of the girls, I couldn't ask for a nicer group to live with. Trying to sleep when there is a rendezvous going on in the next room, or the one above, is occasionally annoying, but then, it happens to all of us so there is some comfort in that. I am also trying to overcome some of my odd traits so that I'll be more pleasant to live with.

I miss some of the parties I used to go to before I came in training. I am trying to realize that I will have to give up a certain number of these things in order to prepare myself for something more important. We are told that there should be a happy medium between professional life and social life—that neither one excludes the other. Some social pleasure must be given up in order to have time to learn how to become a professional person. On the other hand, too much concentration on being professional will not be good for us either because we are social beings and must, therefore, learn how to be gracious and cultured and refined as becomes a human being. I didn't realize before that it is as important to play properly as it is to work properly.

The social gatherings every Monday evening help us to get to know each other and to carry on a more extended conversation than just "Hi-ya!" I am inclined to be boisterous but I am learning to be quiet at the proper times—I hope!

I am so glad that basketball and skating are possible here. I was so afraid that I would not have the opportunity of running all over a basketball court this year. I guess I had the idea that nursing was a 24-hour job. It has been a revelation to find that we have a great deal of free time since the classes and practice in the hospital are limited to eight hours a day. I also like the day off each week which enables me to get home.

I used to belong to the choir at school so it is nice to be able to belong to one again. Although I am no Lily Pons I enjoy using the little talent for singing that I have.

Upon entering this school I have found it necessary to make a big social adjustment. There are so many different personalities and characters that I find it necessary to make many changes in myself in order to mix well with others. I have found many deficiencies in my character and this has awakened in me a desire to develop a friendly, pleasing personality. Quite obvious is the fact that thought for others produces a spirit of unity, which lessens many difficulties and adds pleasure and excitement planning for any sort of entertainment.

I like the responsibilities we have to take as members of committees, like the social, or the decoration and "demolition" squads. (If you are at sea, I was, too, regarding the meaning of this job. It is the special name for the "cleaning-up-after-parties" committee.) Our duties as monitors on the different floors in the residence—to check up on taps left open and lights left on—will help us to develop an observant attitude which is so helpful in a nurse.

I feel that when I have adjusted myself along these various lines I will have developed that sense towards nursing which is known as the professional attitude and which is so essential to the maintaining of a nurse's self-respect. This course in particular has alerted me to the danger of losing the personal touch in caring for patients, while striving so diligently for the professional attitude. I must always endeavor to see beyond the patient's body and realize that his soul is made "to the image and likeness of God." In this way I will be a real nurse. It seems to me that the real beauty of nursing will be in the opportunities I will have of ministering to Christ in the person of the sick. I have begun to realize what grave responsibility devolves upon a nurse and the dignity with which a nurse must always uphold her profession.

Book Reviews

Psychology—Principles and Applications, by Marian East Madigan, Ph.D. 403 pages. McAinsh & Co. Ltd., 1251 Yonge St., Toronto 5. 1950. Price $4.75.

Reviewed by Cecilia May-Schram of Detroit, Michigan.

This text has been written primarily for the use of student nurses. As the author implies in the preface, its function is not intended to be merely informational but therapeutic as well. Not only is the book intended to give an introduction to psychology but to help the

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nurse apply that knowledge in her own personal development and in her contacts with other people.

The book is divided into four units. In the first unit, The Nature and Methods of Psychology, the scientific approach to problems is compared with the biased personal approach and the importance of a scientific attitude is emphasized.

The next unit, The Essentials of Learning, contains a large amount of practical material to help the nurse acquire better study habits. Methods for increasing reading speed are suggested and principles of learning, such as spaced learning, are mentioned.

Militant Angel, by Harriett Berger Koch, R.N. 167 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1951. Price $3.00.

Reviewed by Mary E. Henderson, Educational Director, Metropolitan Health Committee, Vancouver.

This is the story of Annie W. Goodrich, that remarkable American nurse many of us heard and read about in our student nurse days.

The author is herself a nurse. In her preface she tells us that this book had its conception at the meeting of the International Congress of Nurses at Atlantic City in May, 1947. Here she was so thrilled by the vitality, enthusiasm, and insight displayed by this veteran nurse that she was inspired to write an account of her life. In writing this biography, Mrs. Koch says her aim has been to present Miss Goodrich "not alone as a pioneer in the field of nursing education or as the symbol of nursing in America, but as the very real, human person that she is, with ideas, hopes, fears and plans for the future."

The book opens with an account of Annie Goodrich's first night on duty as a student nurse. In the following chapters we accompany the heroine through the rest of her training and subsequent career and there is inevitably a good deal of the history of the training of nurses in those early days. As Miss Goodrich moves from head nurse on through successive positions as superintendent of nurses, university professor, dean of the U.S. Army School of Nursing, dean of the Yale School of Nursing, and prominent leader in professional nursing associations, we see how the transition from one phase to another of her career is a natural outcome of her outstanding ability, keen intellect, and supreme devotion to duty. One realizes how far-reaching the influence of this courageous, brilliant woman has been on nursing and nursing education in the United States.

We are happy to learn that Miss Goodrich now lives in quiet retirement at her home "Far Hills" in Connecticut and we hope she is enjoying the quiet evening of a strenuous, well-spent career.

This book is written in a clear, pleasing style and the author reflects a spirit in full sympathy with the personality of her of whom she writes. We recommend the book, not only to Canadian nurses generally, but to readers in every walk of life.

Orthopaedic Nursing, by Frederick J. Knocke, M.D. and Lazelle S. Knocke, R.N., B.S. 682 pages. The Ryerson Press, 299 Queen St. W., Toronto 2B. 1951. Price $6.25.

Reviewed by Zelma C. Creeden, Assistant to the Director of Nursing, Ontario Society for Crippled Children, Toronto.

In this book the curative and preventive aspects of orthopedic nursing are well defined and illustrated. It will be of value to the student nurse in acquiring fundamental facts, principles, and attitudes relating to the care of the orthopedic patient. To assist the nursing instructor, each chapter is followed by questions for study and discussion with selected bibliography and visual aids. The role of the public health nurse in prevention, case-finding, home care, as well as the rehabilitation program, is clearly defined and discussed.

The more common orthopedic conditions are presented. Poliomyelitis has been used as an example of a disease productive of residual crippling which requires the correlated services of many different professions. It is pointed out that the fundamentals of orthopedic nursing must be applied throughout the acute, subacute, and chronic stages: (1) to minimize crippling results; (2) to help the individual readjust; (3) to utilize to the fullest degree the physical capacity which remains.

Personal posture and body mechanics are reviewed as important basic considerations and application of these appear throughout the text. A chapter is assigned to the psychology of the orthopedically handicapped. The concept of rehabilitation is described and correlated throughout.

Physiotherapy in Obstetrics and Gynaecology (including Education for Childbirth), by Helen Heardman, M.C.S.P. 228 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1951. Price $3.00.

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Reviewed by Bernice Gordon, Victorian Order of Nurses, Vancouver.

Although primarily written for the instruction of physiotherapists who, in the British Isles, have considerable contact with patients on the maternity and gynecological wards, this book still could be of inestimable value to Canadian nurses who wish to broaden their knowledge of the care of these patients. Only a very minor portion of the book is taken up with information that is either basic for nurses or specifically for physiotherapists—e.g., Asepsis for the Physiotherapist.

Natural childbirth, exercises and methods of relaxation in preparation for it, achievement of it and benefits reaped postnatally by mother and baby from it, are given in detail and, in my opinion, constitute the information in this book that could be most frequently applied by nurses. The details on preparation for lactation and for postpartum restoration are also sections which obstetrical nurses would find useful and applicable. The drawings, illustrations, and diagrams clarify the explanations and would make the teaching of the suggested exercises comparatively simple.

The remainder of this book provides excellent background material for anyone having contact with the expectant or delivered mother or the gynecological patient. The scope is wider than that of Mrs. Heardman's previous book, "A Way to Natural Childbirth," and is written more for the professional worker than for the patient.

I would highly recommend it to the staff of public health nursing agencies dealing with prenatal patients, prenatal and gynecological clinics, maternity wards and to obstetricians.

The field of physical therapy has much to offer in the complete care of the patient.

Illustrations of Bandaging and First-Aid, compiled by Lois Oakes, S.R.N., D.N. 308 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 4th Ed. 1950. Price $1.65.

Reviewed by Norma K. Shaw, Instructor of Nurses, Prince Edward Island Hospital, Charlottetown.

The aim of this book is "to enable the student, by means of pictures, to master quickly the science and art of bandaging and of first aid in fractures and hemorrhages." This, in my opinion, is accomplished successfully. The book is divided into seven units, each separate and complete in itself. In these units, the following topics are discussed: triangular bandaging, roller bandaging, shock and its treatment, hemorrhage, fractures, movement and transporting of patients, elastoplast bandaging. The material is presented

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clearly and directly and the content is well organized. The book contains excellent illustrations and this would probably be its greatest value. I feel that it would provide useful reference material for the student and nurse instructor.

Personal Health and Community Hygiene, by Harold S. Diehl, M.A., M.D., Sc.D. and Ruth E. Boynton, M.S., M.D. 469 pages. McGraw-Hill Co. of Canada Ltd., 253 Spadina Rd., Toronto 4. 2nd Ed. 1951. Price $6.10.

Reviewed by Mrs. P. Grace Greenfield, General Hospital, Calgary, Alta.

This book is a revised edition of the successful "Healthful Living for Nurses." Several new chapters have been added, giving more stress to the importance of the nurses' relationship to the community health program.

The authors succeed in giving to the reader an over-all picture of the public health field. Information that is clear and easy to read is supplemented with tables and illustrations. The text is not too general nor too involved to hold the interest of the reader.

Suitable topics for discussion and reference reading are listed following each chapter. The text films that have recently been prepared to correlate with chapters in this book are available and are proving to be a great assistance in presenting several of the subjects. These come in 16-mm. sound films and 35-mm. silent filmstrips.

Students planning to take public health nursing courses will find this book a "must." It points to common diseased conditions found in the everyday life of the nurse and shows how organized common sense can safeguard the student nurse's own health and the health of her patients. Information is given on the organization and administration of health activities.

I feel that this book would be an excellent addition to the school of nursing libraries and should be of great help to teachers.

Trail Riders

Though many Canadian nurses will be holidaying in Eastern Canada next summer following the C.N.A. convention, those who have not yet made their plans may be in-

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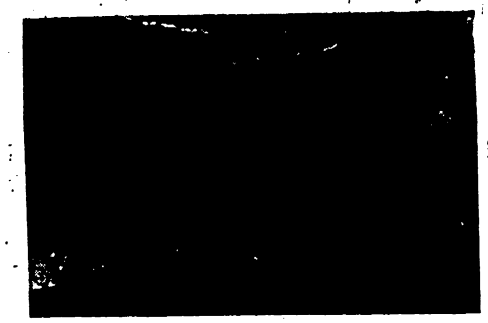
terested in taking part in the annual Trail Ride of the Canadian Rockies. I was with them July 20-25, 1951. I discovered that there were eight nurses in the group of seventy riders.

Established by Dr. John Murray Gibbon in 1923, the aim of the society is to encourage horseback riding over the more remote trails of the Canadian Rockies, to promote good fellowship and an interest in wild life. The secretary-treasurer is *Mr. Graham Nichols, Trail Riders of the Canadian Rockies, Room 284, Windsor Station, Montreal 2, Que.*

We lived in tepees for five days—one snapshot shows tepee town. The other is a group picture of the nurses, except for one who was riding ahead that day. We had a perfectly marvellous time. Each morning we rode out

Left to right: MARJORIE MONROE, Kansas City, Mo.; OLIVE KEMP, Camrose, Alta.; EDITH KEMP, Ponoka, Alta.; R. J. WELSAND, Milwaukee, Wis.; MRS. R. REICHMUTH, Ripon, Wis.; R. CRICHTON, Calgary, Alta.; CAROL ZELLMER, Milwaukee, Wis.



Tepee Town on Mt. Eisenhower

from camp for an all-day ride. The scenery at that elevation (9,000-11,000 feet) is too wonderful for me to describe. Rather than bore readers with too many raves, I would suggest that anyone who wants a *Trail Ride Bulletin* should write now to the secretary.

EDITH D. KEMP
Superintendent of Nurses
Provincial Mental Hospital
Ponoka, Alta.

As you think, you travel; and as you love, you attract. You are today where your thoughts have brought you; you will be tomorrow where your thoughts take you. You cannot escape the results of your thoughts, but you can endure and learn, can accept and be glad. You will realize the vision (not the idle wish) of your heart, be it base or beautiful, or a mixture of both, for you will always gravitate towards that which you, secretly, most love. In your hands will be placed the exact results of your thoughts; you will receive that which you earn—no more, no less. Whatever your present environment may be, you will fall, remain, or rise with your thoughts, your wisdom, your ideal. You will become as small as your controlling desire, as great as your dominant aspiration.

— JAMES ALLEN

Word Game

(*See page 118 for Word Game*)

(A) Action, adobe, alert, aloe, anti, antics.
(B) Beach, bead, bean, bear, beat, bevy, blade, blank, blare, bleach, bleary, bleat, bloat, boar, boat, bode, bold, bole.
(C) Canker, cant, care, cart, carton, cation,

THE ASSOCIATION OF NURSES of the PROVINCE OF QUEBEC

The 1952 Spring Examinations for Provincial Registration will cover two groups of candidates and will be held as follows:

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Graduates desiring to qualify for a licence to practise will write on **April 15, 16 and 17, 1952.** Candidates will not be permitted to write these examinations until they have actually completed their training and hold the diploma of their school. *Applications must be received by March 15, 1952.*

EXAMINATIONS FOR REGISTRATION —PART I:

Students who will have completed their first year will enter the Examinations for Registration, Part I. which will be held on **March 10, 11, 12 and 13, 1952.** (Time to be announced in each school.) *Applications must be received by February 9, 1952.*

For application forms and all information relating to the examinations, apply to the headquarters of the Association.

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Candidates must be British subjects, under 40 years of age, except in the case of ex-service women who are given preference. Application Forms obtainable from all *Government Agencies, the Civil Service Commission, Weiler Bldg., Victoria,* or *636 Burrard St., Vancouver 1,* to be completed & returned to the

Chairman, Victoria.

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Write for information & applications to:

Supt. of Nurses in respective Units or to Director of Nursing, Division of T.B. Control, 2647 Willow St., Vancouver 9, B.C.

cedar, chin, china, chink, chit, cion, citral, cushion.
(D) Dale, dank, dare, dark, darky, darn, dart, dole, ducal, ducat, duct.
(E) Each, earl, earn, education, elan, elation.
(F) Fecal, feud, feudal, foal, fogle, fold.
(G) Glace, glad, glade, glare, glean, gloat, globe, goad, goal, goat, gold.
(H) Hint, hued.
(I) Iced, inky, into, inure, itch.
(J) Join, joint, journal, junk, junta, jury.
(K) Kelp, kern, knit, knot, knur, knurl.
(L) Lace, lade, lank, lanky, lark, latch, lath, leach, lead, lean, leanto, learn, levy, loach, load, loan, loath, lobe, lode.
(M) Moan, moat, moble, modal, mode, molar, mold, mole.
(N) Nark, nary, nice, nitre, notary, notch, notice.
(O) Oath, oblation, ogle.
(P) Peace, peach, peal, pear, pearl, peat, perky, pert, place, plan, plank, plant, plea, plead, pleat, plod, pyre.
(R) Race, rale, rank, rant, ratch, ratio, ration, reach, react, reaction, read, real, relation, reload, replace, replant, runt.
(S) Scald, scale, scaler, scalp, scan, scant, scar, scare, scat, scion, scud, shin, such, suction, sudation, sued.
(T) Tach, tael, tale, tank, tanker, tare, tarn, thin, think, thinker, thud, thus, tinker, tonal, tour, trace, trade, tread, trey, trunk.
(U) Unit, unitary, unread, unreal, unto, untread, urea.
(V) Veal, velar, vert, vertical, very.
(Y) Yean, year, yearn, yeld, yelp, yerk.

News Notes

ALBERTA

JASPER

At a meeting of Edith Cavell Chapter, when 11 members and three Sisters were present, it was reported that Mmes M. Douglas and White had attended a Civil Defence Course in Edmonton. An itemized report had been received from the Department of Public Health regarding the tuberculosis survey. Mrs. Brodie will look after the visiting of members who are ill during the coming months. Films were shown on "Blood Banking Transfusion," "Venapuncture and Intravenous Therapy," and on "Pentothal Sodium Administration" by Mr. A. Holland of Abbott Laboratories Ltd.

BRITISH COLUMBIA

CHILLIWACK

Dr. F. B. Bryson, associate member of Crease Clinic and Essondale Mental Hospital, was guest speaker when members of Chilliwack Chapter met at the local hospital. His subject was "Treatments Used in Institutional Psychiatry." The Crease Clinic of Psychological Medicine, located in a building of the Essondale group, is a unit in itself, separate from the Mental Hospital. The opening of the clinic has been a great step forward, the speaker asserted. Voluntary patients, and there are an increasing number of them, come to the clinic. Doctors send patients to the clinic when it is believed they will benefit from short-term treatments. Usually the care does not exceed four months.

It was reported that a contribution was made to the Needy Nurses Fund. Red Cross home nursing classes are being held under the supervision of Mrs. B. Barwell.

LADYSMITH

A Red Cross nursing loan cupboard will be sponsored here by the Graduate Nurses' Association. This was decided following a conference report by Mrs. E. Brown, nursing division chairman of the Red Cross. Mrs. J. W. Neville presided over the discussion. A report on the annual B.C. Hospital Association convention at Vancouver by Mabel Leggett, matron, told of advances made in both hospital equipment and in designs for new hospitals. It was decided to purchase a surgical dressing carriage for the local hospital. Mrs. D. B. Quayle gave highlights of the Cowichan-Newcastle Chapter meeting in Duncan.

Mmes N. Steele and M. Duncan were in charge of the Christmas party.

NEW WESTMINSTER

Mr. J. Renton of Port Coquitlam, a well known B.C. horticulturist, gave an interesting talk on home gardening and how plants grow at a recent meeting of New Westminster Chapter. Mrs. J. Coulter was appointed to attend a three-day nursing course, arranged by the Department of National Health and Welfare. Donations were made to the Elks' Christmas Cheer Fund, Salvation Army, CKNW Orphans' Fund, and to CNIB. B. I. Smith and M. Lang were to make arrangements for the Christmas party. The president, G. Smith, was in the chair. Tea hostesses were Mmes D. Coutts, E. Jarvis, and Miss P. Wright.

PRINCE GEORGE

The "Deep South" was the theme running through the decorations of a ball sponsored by Fort George Chapter. Proceeds went towards providing a bursary for a student at the high school desirous of taking nursing training and also towards purchasing a new piece of equipment for the nurses' residence at the hospital. The committee for arrange-

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ments included Mrs. C. Geddes, chapter president, G. Gowans, Mmes T. Green and K. Allan.

Olga Moores is now assistant matron at Prince George and District Hospital. A graduate of Saint John General Hospital, N.B., she was previously on the staff of the hospital at Prince Rupert.

South Fraser Chapter

At a recent dinner meeting of the chapter, Lily Slater of Aldergrove, a student nurse at the Vancouver General Hospital, was presented with the Dr. F. D. Sinclair Bursary, worth $150, by Mrs. Sinclair. The bursary is awarded each year by the chapter in memory of Surrey's former medical health officer. Alice Wright, R.N.A.B.C. registrar, was guest speaker and her talk dealt with developments in nursing education.

Vernon

The Vernon Chapter sponsored a bridge and canasta party, realizing $35 which will go towards the student nurse bursary. Prizes were won by Mmes Knox, F. F. Becker, and W. E. Bitz. Refreshments were in charge of Mmes H. R. Hunter and A. Edwards.

MANITOBA

Portage la Prairie

Mrs. A. Bryson was elected president of the Portage Graduate Nurses Association at a recent meeting when the following officers were also chosen to serve: Vice-president, R. Hyde; secretary, Mrs. B. Dalzell; treasurer, Mrs. G. Young. Committees: Education, Miss Thomson; entertainment, Mrs. D. Turko; lunch, Mmes A. Wilkenson, N. McPhedran; flowers, Miss Palmer, Mrs. L. Adams.

At this meeting, when 24 nurses were in attendance, a new association was formed with the main project being civil defence. It is hoped that classes will soon be started when resident volunteers will be taught the work of defence

NEW BRUNSWICK

Moncton

At a meeting of Moncton Chapter, a report was given by Myrtle Kay on an overseas parcel of food and clothing sent to a home for retired nurses in Edinburgh. Miss Kay also commented on the table-setting contest sponsored by the I.O.D.E. By popular vote, a $50 prize was awarded to the chapter for having the best table. A Christmas tree and sale were highlights of the evening. A meeting of the Registry Board was held prior to the chapter meeting.

Nurses' Hospital Aid

Mrs. J. Pettet welcomed three new members —Mmes J. S. Neil, F. B. Robinson, and R. Colpitts—at a Nurses' Hospital Aid meeting. Mrs. Nash-Smith read a letter from L. A. Porter with regard to by-laws and regulations governing Hospital Aids. Reports

were heard from Mrs. R. Buchanan on the "Rolling Dollar," Mrs. C. McKee from the Local Council of Women. Mrs. K. Carroll had the "Dollar" for November. Mrs. J. Morrell announced that the Aid had been offered the opportunity of serving tea at the opening of the new Unemployment Insurance offices. It was decided to donate a sum of money for a gift to the nurses' home and for the ward children of Moncton Hospital. Refreshments were served by Mmes A. A. Happer, McCully, R. Buchanan, and L. Munn.

Saint John

The local chapter, on the recommendation of the private duty nurses, decided to hold a public bridge to help finance the nurses' registry office. F. Saunders, the president, was in the chair. Mary Flett gave an interesting talk on new books and the works of Canadian authors of whom she gave brief biographical sketches.

St. Joseph's Hospital

M. McDermott, president, was in the chair at a regular meeting of the alumnae association. Plans were made for the annual card party.

NOVA SCOTIA

Glace Bay

General Hospital

At a recent meeting of the alumnae association the vice-president, Mrs. A. Caldwell, was in the chair. M. MacDonald gave a satisfactory financial report and it was stated that the home-cooking sale had been successful. A donation was made to the Students' Year Book. Plans were made for the Christmas party to which the members were to bring children's gifts and clothing for needy families. S. Crowell accepted the office of treasurer on the resignation of Miss MacDonald.

ONTARIO

District 1

Strathroy

A meeting of the General Hospital Alumnae Association was held recently with the retiring president, B. MacDonald, in the chair. Plans were discussed for a bazaar and bake sale, with M. Bragan nominated as convener, assisted by Mmes S. McLeish and C. Gibson. Final arrangements were made for the annual dance. Following an enjoyable lunch provided by the hostesses, G. MacDonald and Mrs. S. Brough, a set of matched luggage was presented to M. Dinning, evening supervisor of the hospital for the past four years, with the deep appreciation of the staff for her many hours of service. Miss Dinning has accepted a post at Alma College, St. Thomas.

The following officers will serve during the coming months: President, I. Urquhart; vice-president, Mrs. E. England; secretary, Mrs. H. Frank, Jr.; treasurer, F. Bloomfield; gift

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Supt. of Nurses, General Hospital, Winnipeg, Man.

fund, A. McCracken, Mrs. S. McLeish; press reporter, F. Riley. A hearty vote of thanks was tendered the retiring officers by D. Doan on behalf of the association.

District 2

Simcoe

The standing committees of the Community Nurses' Registry were named at a meeting of the Board of Directors. M. Holland, the president, was in the chair. Included were the following: D. Bowden, M. Holland, R. Misner, B. Skinner, Miss Clark, Mmes H. J. Brook, R. McIntosh, R. White, J. Smith.

The progress of the registry was reviewed and the question of offering the services of the registry for the civil defence program was discussed.

Stratford

Mrs. C. Walkom, president, was in the chair at a meeting of the board of directors of the Community Nursing Registry. Mrs. W. J. Byrick, registrar, gave the financial statements and registry work report from September 1 to November 22. Mrs. M. Stoskopf gave the recommendations of the special committee set up to study non-attendance. Mrs. M. Peterson, credential committee convener, recommended three nursing assistants for membership, this recommendation being accepted. Miss Murray reported on the annual meeting of Districts 2 and 3 held in Kitchener while Mrs. Byrick commented on the Institute for Registry Personnel held in Hamilton.

District 3

Chesley

The gift of a lovely radio-phonograph for the nurses' residence of the District Memorial Hospital has been made in memory of the late Mrs. Pauline Bierworth by her sisters—Mrs. A. Milne, Elmwood; Mmes J. Graham, D. McLennan, and C. Shantz.

Guelph

On her recent trip to Guelph, when she was guest speaker at a meeting of the Women's Canadian Club, Ella Roulston, matron of the Department of National Health and Welfare Indian Hospital at Moose Factory, Ont., was taken on a tour of the new General Hospital by Dr. E. Martin.

In her address, Miss Roulston said that since the opening in 1950 of the hospital at this Indian reservation on the south shore of James Bay, the death rate among the Eskimos and Indians of Northern Ontario has dropped noticeably. The two and one-half million dollar hospital is situated on an island at the mouth of the Moose River, 670 miles north of Toronto. Located near a large Hudson's Bay trading post, the hospital offers modern medical care to thousands of Indian trappers and their families.

With the aid of a large map and a number of colored films Miss Roulston explained the location of the hospital, the climate, and the inhabitants of the north.

Kitchener

Over 500 guests attended the annual dinner and formal dance held by the Student Nurses' Association of Kitchener-Waterloo Hospital. Receiving the guests were F. MacDougall, president of the association, C. Adams, director of nursing education, and members and wives of the medical staff.

District 5

Toronto

St. John's Hospital

The annual alumnae association dinner was held at the St. John's Convalescent Hospital, Newtonbrook, with a good attendance. Following dinner and vespers in the chapel a meeting was held when a cheque for $250 was presented to Sr. Beatrice, representing the initial payment towards the furnishings for a private room in the new addition to the hospital.

Mrs. R. R. (McIlroy) Marshall, a St. John's graduate who was awarded "The Vellum Vote of Thanks of the Grand Priory of St. John of Jerusalem," spoke of her work in China during the Japanese occupation. A letter of thanks was read from J. Vanderwell who is serving for three years with the American University Hospital in Beirut, Lebanon.

A tour of the new wing and the third-floor addition was enjoyed by the members.

Women's College Hospital

Harriet T. Meiklejohn was honored when the alumnae association announced a new scholarship had been founded in her name. Miss Meiklejohn joined the hospital in 1927 and remained there until her retirement. She was graduated in arts from McGill University in 1903 and studied nursing at New York Presbyterian Hospital, graduating in 1909. She went overseas as a nursing sister in World War I, returning to Canada in 1919. In 1925 she became superintendent at St. Catharines General Hospital where she remained until coming here in 1927.

The scholarship will be competed for yearly by W. C. H. graduates, the $300 being awarded for post-graduate study, after which the nurse must return to the hospital for at least a year.

District 7

Brockville

Mrs. L. Park, chairman, presided at a meeting of Brockville Chapter when around 50 members attended. The business portion of the program was taken up with preparations for the Autumn Ball when reports were heard from the various conveners. Mrs. Wilkins reported that a local jeweller had donated the door prize. Sr. M. Clare gave a report of the nominating committee.

Colored films, taken by Rev. Gordon S. Maxwell when he represented the United Church of Canada at a Congregational Assembly in Britain, were shown. He was

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introduced by V. Preston and thanked by Mrs. M. Wilkins.

Smiths Falls

Mrs. B. Greenham, who spent a vacation in Scotland, was guest at a meeting of Smiths Falls Chapter when she gave the highlights of her trip. Mrs. D. Carson, chairman, presided.

District 8

Ottawa

St. Luke's Alumnae

A successful tea was held under the auspices of the alumnae when proceeds went for charitable purposes.

District 9

Timiskaming

Twenty-two nurses were in attendance at a meeting of the Graduate Nurses Association held at the home of Mrs. D. Wall. Mrs. Cosman read the secretary's report and Mrs. Kosmack commented on the financial situation of the group. Two tea-cosies, received from Miss Cairns in Scotland, were displayed and were to be raffled at the nurses' Christmas party held at the home of Mrs. Ross. A Christmas parcel, packed by the members, was forwarded to Miss Cairns. Mmes Lefevre and Fitzgerald were to look after the "Christmas Dinner for Eight" basket. After adjournment, an interesting talk was given by Miss McCready.

District 11

Gravenhurst

The inaugural meeting of District 11 was held at Muskoka Hospital with approximately 130 present. G. Sharpe, R.N.A.O. president, was guest speaker. M. Tresidder, District 5 chairman, A. E. Fenton, R.N.A.O. public relations secretary, and F. Hendrikz were also present. Miss Tresidder brought greetings from her district and presented to the new district a chairman's gavel. Sr. St. Camillus, District 9 chairman, was unable to attend but sent greetings through B. Houston.

It is hoped that this district, though large and somewhat isolated in parts, has made a good start towards enabling the nurses in the area to attend meetings some time during the year.

The new officers, installed by Miss Fenton, include: Chairman, J. Killorin, Orillia; vice-chairmen, Mrs. M. E. Gulliver, Parry Sound, and M. B. Lowe, Barrie; secretary-treasurer, D. Rowlandson, Orillia. Councillors: Mrs. A. Clark, Bracebridge; Mrs. E. Groh, Gravenhurst; Sr. St. William, Parry Sound; B. R. L. Brown, Orillia; M. McKinley, Barrie; Mrs. A. LeMay, Penetang; M. Masters, Collingwood.

QUEBEC

Montreal

General Hospital

The following will be thrilling news to all M.G.H. graduates—near and far: On December 11, 1951, at 11:45 a.m. civic and religious dignitaries gathered on the slope of Mount Royal for a formal ceremony, marking the start of construction of the new 750-bed Montreal General Hospital, between Pine and Cedar Avenues. Major Norsworthy, president of the hospital, presided at the ceremony and other distinguished citizens present included: Hon. A. Paquette, Provincial Minister of Health; Rt. Rev. John Dixon, Mayor C. Houde, Dr. F. Cyril James, Dean G. Lyman Duff, Rev. Victor Rose, and Rev. J. S. McBride.

With a mechanical shovel operator as his instructor, Dr. Paquette took over the controls for a mechanized turning of the first sod. Mrs. Alex Hutchison, president of the hospital's Women's Auxiliary, launched the great new enterprise by casting a champagne bottle against the shovel scoop.

According to the present building schedule, the structure will be completed in 1954.

Eileen Ingram left for Birmingham, Eng., on an exchange basis to do public health nursing.

SASKATCHEWAN

Moose Jaw

The members of the Moose Jaw Chapter were fortunate in having for their guest speaker at a recent meeting Dr. Derek Millar, psychiatrist of the staff of the Saskatchewan Hospital, Weyburn. Dr. Millar said the concern of drama, literature, and also of psychiatry has been the conflict arising from people's attitudes toward one another. Of great importance is the "stage" setting in which we live and the other actors on the stage—whether in school, hospital, or at home.

Mrs. L. Devenny presided at the meeting held at the Regional Health Centre.

Regina

"The general duty nurse is the real bedside nurse," Patricia McGrath stated at a meeting of Chapter 7 held at Grey Nuns' Hospital. Miss McGrath, nursing consultant for the provincial government, made this statement during a symposium on "The General Staff Nurse." This symposium had been arranged by the Institutional Committee which was in charge of the program for the evening. E. Robertson, nursing arts instructor at the General Hospital, carried on the discussion by stressing the importance of an adequate orientation program for the general duty nurse. Mrs. E. Arnoll, surgical clinical instructor, Grey Nurses' Hospital, presented a paper on the value of promotion to a general duty nurse.

Miss McGrath, in her second address, emphasized the value of service. Inez Caza, nursing arts instructor, General Hospital, spoke briefly on the value of an educational program.

Saskatoon

St. Paul's Hospital

The alumni association held its Christmas party when members from as far afield as California participated. The student nurses also held their annual Christmas concert. A welcome was extended to Lola Wilson, S.R.N.A. registrar, who came to the school to interview third-year nurses. M. Mackenzie and S. Leeper attended an institute in Regina on "Nursing Aspects of A.B.C. Warfare."

In January, the Cultural Committee arranged a skating party on the new rink which was made for the students as a Christmas gift from Sr. Superior.

Sr. Paulette Fortier, operating room supervisor, has written another of her informative pamphlets. This time it concerns the typhus epidemic of 1847 and is entitled "Shaking Hands with Death."

A reluctant "goodbye" was said to 21 of the third-year nurses. A welcome is extended to 30 new Freshmen B.

A recent visitor to the school was E. (Worobetz) Gault who now resides in Red Deer, Alta.

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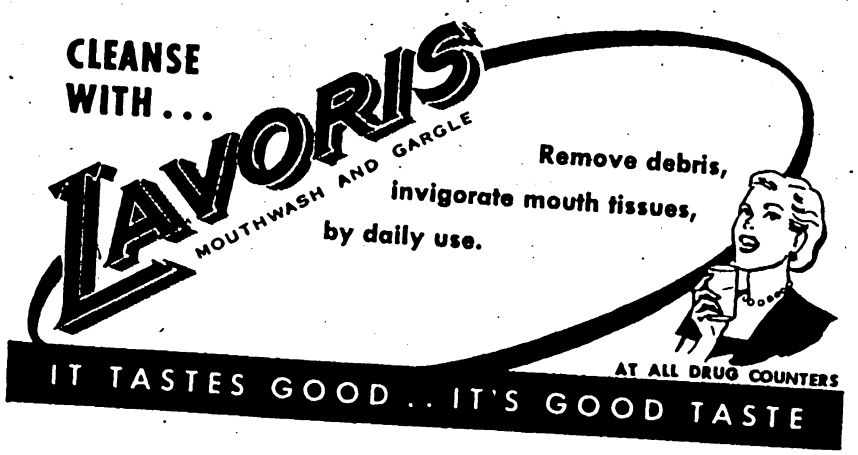

Positions Vacant

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Matron immediately for new 26-bed hospital. Private suite in hospital. 3 wks. annual vacation with pay after 1 yr. service. Apply, stating salary expected, S. Hancock, Sec.-Treas., District Hospital, Minnedosa, Man.

Matron (experienced) for 31-bed hospital situated on both C.P.R. & C.N.R. Salary: $250 gross less $30 for maintenance. Modern separate matron's residence. 25 on staff & 2 doctors. Apply Mr. J. P. Fawcett, Sec.-Mgr., Union Hospital, Unity, Sask.

Operating Room Supervisor with post-graduate course & experience for 200-bed hospital —active service. School of Nursing. Gross salary: $205-255. Charge of $30 for maintenance if living in residence. 44-hr. wk. Also **Night Supervisor,** capable of taking charge of hospital, including delivery room. Gross salary: $215-275. 44-hr. wk. May live in residence. For full particulars apply Supt. of Nurses, General Hospital, Moose Jaw, Sask.

Science Instructor for Royal Jubilee Hospital School of Nursing, Victoria, B.C. Student body, 200. Instructor to have degree or certificate in teaching, with preparation & experience to teach sciences. Apply, stating qualifications, to Director of Nursing.

General Staff Nurses for 165-bed General Hospital in residential suburb of Chicago. Cash salary: $205 for day duty, $215 evening duty & $220 night duty. Full maintenance in addition to salary includes single room in new nurses' residence. $10 increase after 60 days & at regular intervals thereafter. 2-4 wks. vacation. 6 holidays. Sick time policy. Scrub Nurses—remuneration for call. Leave of absence with part salary for post-graduate experience. Apply Director of Nursing, MacNeal Memorial Hospital, Berwyn, Illinois.

Instructor & Supervisor for 165-bed General Hospital in residential suburb of Chicago. Duties primarily teaching & supervision of auxiliary nursing personnel. Cash salary: $265 plus full maintenance in new nurses' residence. 44-hr. wk. Apply Director of Nursing, MacNeal Memorial Hospital, Berwyn, Illinois.

General Duty Nurse immediately for 33-bed hospital. Salary: $150 plus full maintenance. 8-hr. broken day. 3 wks. holiday after 1 yr. service. Apply Supt., Little Long Lac Hospital, Geraldton, Ont.

Graduate Nurses (2) for General Duty for 6-bed hospital. Salary: $165 per mo. with full maintenance. Shift work. 8-hr. day, 6-day wk. Also position open for **Matron** in Sept. Salary: $185. Apply D. Johnson, Matron, Union Hospital, Arborfield, Sask.

Dietitian (qualified) for Teaching Hospital. Opportunity for advancement. Full maintenance. Fare from Canada for accepted candidate. For full particulars write, giving qualifications & date available, Matron, King Edward VII Memorial Hospital, Bermuda.

Supt. by Feb. 22 for 100-bed modern hospital. Supt.'s suite in residence. 1 mo. vacation per yr. with pay. Apply, stating qualifications, experience, age & salary expected, Sec., Payzant Memorial Hospital, Windsor, N.S.

Matron for 24-bed, well equipped hospital, built little over 3 yrs. Good salary. Apply in writing or personally to Clayton Schaus, Sec., Chesley & District Memorial Hospital, Chesley, Ont.

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invites applications for Administrative and Staff positions in Hospital, Public Health Nursing Services, and Blood Transfusion Service for various parts of Canada.

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National Director, Nursing Services, Canadian Red Cross Society, 95 Wellesley St., Toronto 5, Ontario.

Clinical Supervisor in Obstetrical Nursing by March 15. Apply, stating experience, Director of Nursing, Women's College Hospital, Toronto 5, Ont.

Graduate Nurses for General Duty (2) immediately. Salary: $195 per mo. Room & board, $45 per mo. $75 refunded towards travelling expenses after 1 yr. service. 4 wks. holiday after 1 yr. service. Annual increment, $5.00 per mo. Up to date & well equipped 25-bed hospital. Apply St. Mary's Hospital, Dawson, Yukon Territory.

General Duty Graduate Nurses for 60-bed Acute General Hospital, situated 150 miles northeast of Vancouver on B.C. coast. Salary: $222 per mo. less $25 for complete maintenance & laundering of uniforms. 4 wks. holiday with pay plus 10 statutory holidays. Transportation advanced if desired. Apply Matron, St. George's Hospital, Alert Bay, B.C.

Graduate Nurses for General Duty in 200-bed hospital in Niagara Peninsula. Salary: Days $140; evenings $150; nights $145, plus full maintenance in attractive residence. 48-hr. wk., no broken shifts. 21 days vacation plus 8 statutory holidays. Train fare refunded at completion of 1 yr. service. Increments & cumulative sick leave. Apply Director of Nursing, County General Hospital, Welland, Ont.

Matron for new 8-bed hospital which has latest equipment available. Salary: $200 per mo. & full maintenance. Apply F. C. McMurchy, Sec.-Treas., Reston, Man.

Registered Nurses & Ward Supervisors for Winnipeg Municipal Hospitals: 548 beds, 3 units; communicable, tuberculosis & chronic diseases. Salary: for Nurses, $168-197 per mo.; Supervisors, $180-208 per mo. with $10 per mo. semi-annual increase. Excellent personnel policies, working conditions, annual vacation, statutory holidays, liberal sick benefits. Apply Personnel Manager, City of Winnipeg, 160 Princess St., Winnipeg, Man.

Graduate Nurses for 56-bed hospital. Basic salary: $200 gross. $10 annual increments. Full maintenance $44. Excellent residence. Ample recreational facilities. Vacations, statutory holidays, sick allowance. Apply Supt. of Nurses, Wrinch Memorial Hospital, Hazelton, B.C.

Clinical Instructor in Communicable Disease. Salary range: $270-280 per mo. **General Duty Staff Nurses** for Medical, Surgical, Obstetrical & Communicable Disease Depts. & Operating Room. Salary range: $1.30-1.40 per hr. ($247-266 per mo. based on 44-hr. wk.). Planning for 40-hr. wk. Differential of $0.10 per hr. for evening & night duty. 3 wks. vacation with pay after 1 yr. service. 2 wks. paid sick leave. General Hospital, 14 miles from Chicago, near Lake Michigan. University affiliation. Apply Director of Nurses, Evanston Hospital, Evanston, Illinois.

Asst. Supervisor of Operating Room—experience & post-graduate study necessary. Beginning salary not less than $167.50 plus 2 meals & laundry with additional recognition for graduate study & years of experience. Annual increments, vacation & sick time on salary. **General Duty Nurses.** Basic beginning salary: $147.50 plus 2 meals & laundry. 8-hr. day, straight shift. Evening & night duty differential. Vacation & sick time on salary. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

Supt. for very active 28-bed hospital in Western Ontario. Apply, stating qualifications & salary expected, Mrs. G. Rothwell, Sec., General Hospital, Palmerston, Ont.

Registered Nurses for General Duty for 50-bed hospital in town on Lake Ontario, near Toronto. Salary: $170 per mo. with additional $10 for 4-12 duty. Apply Supt. of Nurses, General Hospital, Cobourg, Ont.

Matron immediately for 17-bed hospital. Busy, full-range surgery. Beautiful surroundings in friendly community. Starting salary: $225 less $40 board & room. Apply Sec., Bruce Memorial Hospital, Invermere, B.C.

Operating Room Supervisor. Salary: $210 per mo. gross. **General Duty Nurses.** Salary: $165-175 per mo. gross depending on experience. **Asst. Night Supervisor.** Salary: $190 per mo. gross. 44-hr. wk. 2½ days holiday per mo. Half day on statutory holidays. 1½ days per mo. sick time cumulative to 30 days. Charge of $30 per mo. made for board & room. Apply Supt. of Nurses, General Hospital, Medicine Hat, Alta.

Asst. Supervisor for Operating Room of 450-bed General Hospital. Apply, stating qualifications & salary expected, Director of Nursing, General Hospital, Saint John, N.B.

General Duty Nurses for 200-bed hospital. Salary: $175 plus Cost of Living Bonus. 8-hr. day, 88-hr. fortnight. Statutory holidays. Sick time. 4 wks. annual vacation. Apply Supt. of Nurses, Royal Inland Hospital, Kamloops, British Columbia.

Dietitian for 100-bed hospital. Salary depends on experience & qualifications. For particulars apply Supt., Soldiers' Memorial Hospital, Campbellton, N.B.

Asst. Dietitian (qualified) for 225-bed hospital. Apply Chief Dietitian, Moncton Hospital, Moncton, N.B.

Science Instructor. Post-graduate course in Nursing Education; degree desired. Initial gross salary: $105 bi-weekly plus Cost of Living Bonus. **Nursing Arts Instructor**—nurse experienced in bedside nursing & ward administration with post-graduate course in Teaching & Supervision. Initial gross salary: $99 bi-weekly plus C.O.L. Bonus. **Clinical Instructors** (3)—(a) Pre-clinical students (b) medical (c) surgical. Initial gross salary: $99 bi-weekly plus C.O.L. Bonus. For other perquisites—vacation, illness, pension, etc. & further information—apply Supt. of Nurses, General Hospital, Hamilton, Ont.

Pediatric Supervisor, preferably one with certificate in Teaching & Supervision, for 40-bed unit in 450-bed General Hospital. Basic salary: $240 per mo. with yearly increments. 11 statutory holidays. 4 wks. annual vacation. Apply, giving full details, Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

Obstetrical Teaching Supervisor for 58-bed dept. (800-bed hospital). Salary open. Experience & advanced preparation required. Duties include teaching & supervision of nursing care. Living in optional. Good working conditions. Details on request. Apply Supt. of Nurses, General Hospital, Regina, Sask.

Scrub Nurses for Operating Room for General Hospital, Regina, Sask. Salary commensurate with preparation & experience. Apply Supt. of Nurses.

Graduate Floor Duty Nurses for Mt. Hamilton Maternity Hospital, Hamilton, Ont. 44-hr. wk. Statutory holidays. Initial gross salary bi-weekly: $79 plus Cost of Living Bonus. For other perquisites & further information write Supt.

Graduate Floor Duty Nurses for General Hospital, Hamilton, Ont. Gross initial bi-weekly salary: $79 plus Cost of Living Bonus of approx. $3.00. 44-hr. wk. For other perquisites & further information write C. E. Brewster, Supt. of Nurses.

General Duty Nurses for 350-bed Tuberculosis Hospital in centre of Laurentian summer & winter resort area, 2 hrs. from Montreal. Starting salary: $125 per mo. plus full maintenance. Attractive working hrs. with 1½ days off weekly & 1 week-end each mo. 1 mo. annual vacation. 14 days sick leave. Apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

General Duty Nurses for 107-bed modern hospital. Starting salary: $165 per mo. plus meals & laundry. Additional for night duty. Increase at 6 mos. & annually thereafter for further 2 yrs. 44-hr. wk. 8 statutory holidays. 21 days holiday after 1 yr. service. Travelling expenses refunded after 6 mos. from point of entry into Ont. Cumulative sick time. Medical & hospital plans available. Apply Supt. of Nurses, Kirkland & District Hospital, Kirkland Lake, Ont.

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Registered Nurses for General Staff for Ontario Hospitals in Brockville, Hamilton, London, New Toronto, Orillia, Smiths Falls, St. Thomas, Toronto, Whitby, Woodstock. Gross salary: $2,260 per annum with maximum salary of $2,660, less perquisites ($26.50 for room, board, laundry). Cumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 44-hr. wk. Apply Supt. of Nurses at above hospitals.

General Duty Nurses for modern, well-equipped hospital in picturesque Lakehead. 45-hr. wk. Cumulative sick leave. 1 mo. vacation after 1 yr. service. Gross salary per mo.: $185 less $20 for meals. A further $25 charged if living in residence. Annual increment. Railway fare up to $50 with 1 yr. contract. **Pediatric Supervisor** (teaching & administrative), $225. **Asst. Night Supervisor.** Rotating 3-11, 11-7. $225-235 depending on qualifications. Apply Director of Nursing, General Hospital, Port Arthur, Ont.

Public Health Nurse immediately for No. 9 (Red Deer) Health Unit, Alta. Salary range: $2,160-2,760. Superannuation. 3 wks. annual holiday. Sick leave. Apply Dr. C. G. More, M.O.H., Red Deer, Alta.

Registered Nurses (2) for General Duty in 25-bed General Hospital. 8-hr. duty. 44-hr. wk. 2 wks. rotation. Salary: $155 per mo. plus full maintenance. Apply Supt., Louise Marshall Hospital, Mt. Forest, Ont.

Graduate Nurses. Salary: $210 per mo. Apply. Supt., Warren Hospital, Warren, Minnesota.

Graduate Nurses for 200-bed Tuberculosis Sanatorium at Nanaimo, Vancouver Island, B.C. Services include major surgery, orthopedic & pediatric nursing. Salary: $192 per mo. for recent graduates; $215 for nurses with 3 yrs. experience since graduation with yearly increments. Single room, board & laundry provided for $30 per mo. Hospital has beautiful location, excellent climate & comfortable quarters. Apply, stating qualifications & experience, Matron, Nanaimo Indian Hospital, Nanaimo, B.C.

Graduate Nurses for completely modern West Coast hospital. Salary: $210 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. **Operating Room Supervisor.** Starting salary: $250 per mo. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

General Duty Nurses. Salary: $163.40 (one sixty-three dollars & forty cents) monthly, paid on a bi-weekly basis; 26 pays in a yr. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day: 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ontario.

Staff Nurses—all Depts. Optional—44- or 40-hr. wk. in all depts. Remuneration accordingly. 8-hr. day. $11, day duty; $12 per day, afternoon or night duty. 25 miles north of Detroit. Apply Director of Nurses, St. Joseph Hospital, Mt. Clemens, Michigan.

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Graduate Nurses for General Duty (2) at once for 36-bed hospital. Salary: $145 per mo. with full maintenance, increasing to $150 end of 6 mos. 8-hr. day., straight shift. 1 mo. holiday with pay end of 1 yr. Sick pay. Progressive growing town of 2,500 on C.P.R. main line & Trans-Canada highway. Community, social & recreational facilities. Apply, stating qualifications & experience, Mr. H. J. Peddie, Sec.-Treas., Municipal Hospital, Brooks, Alta.

Graduate Nurses for General Duty on Medical, Surgical & Obstetrical floors in 85-bed hospital, located near Chicago. Also **Surgical Supervisor & Central Supply Supervisor.** Starting salary: $255 with afternoon bonus $30 & night bonus $20. Apply Personnel Director, Highland Park Hospital, Highland Park, Illinois.

Registered Nurses for General Duty for small General Hospital. Salary: $125 per mo. with full maintenance. 6-day wk. 8-hr. duty, rotating shifts. 3 increments of $5.00 per mo. at 6-mo. intervals. Blue Cross paid. 10 days sick leave per yr. 6 statutory holidays. 28 days holiday. Apply Lady Supt., Barrie Memorial Hospital, Ormstown, Que.

Graduate Nurses for Staff Duty—Medical, surgical & obstetrical services. Beginning salary: $250 per mo. Increase every 6 mos.—Maximum $270. $10 additional per mo. for operating or birthroom service. Extra remuneration for afternoon & night duty. 5-day, 40-hr. wk. Apply Personnel Dept., Florence Crittenton Hospital, 1550 Tuxedo Ave., Detroit 6, Michigan.

Registered Nurses for General Staff (2) in 21-bed hospital. Salary: $140 per mo. Room, board, uniform laundry provided. Rotating shifts. 48-hr. wk. Blue Cross Plan. 3 wks. holiday after 1 yr. service. Also **Nurses' Aide.** Apply Supt. of Nurses, General Hospital, Espanola, Ontario.

General Duty Nurses for Operating Room, Pediatrics & Surgical & Medical Nursing. For information & personnel policies apply Director of Nursing, Victoria Hospital, London, Ont.

Operating Room—General Staff Nurses. Gross monthly salary: $193.50 ($210.50 less perquisites, 2 meals & laundry, $25.50). 8-hr. day, 44-hr. wk. Apply Director of Nursing, Civic Hospital, Ottawa, Ont.

Registered Nurses (2) for General Duty in new modern 20-bed hospital. Salary: $160 per mo. & full maintenance. Duties to commence immediately. Apply P. J. Rasmussen, Sec., Union Hospital, Climax, Sask.

General Duty Nurses for small hospital. Salary—Registered Nurses, $160 per mo. plus full maintenance; others according to qualifications. Apply Supt., Lady Minto Hospital, Cochrane, Ontario.

Instructor of Nursing (1) **& Clinical Supervisor** (1). Apply Director of Nursing, Victoria Public Hospital, Fredericton, N.B.

Residence Nurse immediately. Apply Secretary, University of Toronto School of Nursing, 7 Queen's Park, Toronto 5, Ont.

Nurses—O.R., Medical, Surgical, Anesthesia. All shifts—no rotation. 5 days—40 hrs. Mo. vacation. Paid sick leave & holidays. Starting salaries: $220 for staff; $240 for specialties; $250 for supervisors. Late shifts bonus. Periodic increments. Living-in available. Apply Director of Nursing, Maimonides Hospital, 4802-10th Ave., Brooklyn 19, New York.

Registered Nurses for Sunnybrook & Westminster Hospitals, Toronto & London, Ont. Salary: $2,300-2,930. Information & application forms available at Post Offices. The latter should be filed with the Civil Service Commission of Canada, 1200 Bay St., Toronto 5, Ont., as soon as possible.

Registered Nurses (3) for General Duty immediately. Salary: $150 per mo. with full maintenance & transportation paid. Modern town with all sports, theatre. Near airport. Pop., 1,200. Apply C. W. Bawtinheimer, Matron, K.H.P. Hospital, Bonnyville, Alta.

Registered Nurse (experienced; over 40) to take charge of 21-bed Convalescent Home at 6862-11th Ave., Rosemont, Montreal 36, Que. Sleep in. When applying state qualifications, references & salary expected.

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Interview desirable prior to employment. *Write to:*

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Floor Supervisor, Asst. Floor Supervisor, Nursery Supervisor, General Duty Nurses immediately for 150-bed General Hospital. New wing & nurses' residence. 1 mo. vacation in addition to salary. Supervisors: $170 plus full maintenance. Asst. Supervisors & General Duty Nurses: $150 plus full maintenance. Apply Director of Nursing, General Hospital, Brockville, Ont.

Registered or Graduate Nurse (preferred) or **Practical Nurse** (resident) for Girls Cottag School, St. Bruno, Que. 15 miles from Montreal. Salary depending on qualifications. For information apply to school or phone St. Bruno 113.

Public Health Nurse for Township of Etobicoke staff. Minimum salary: $2,200. Allowance made for previous experience. Transportation allowance. Apply Medical Officer of Health, Township of Etobicoke, Municipal Bldg., 4946 Dundas St. W., Toronto 18, Ont.

Public Health Nurses for clinic & home visiting program in tuberculosis. 5-day wk. 31 days holidays. Statutory holidays. Apply Supervisor, Public Health Dept., Royal Edward Laurentian Hospital, Montreal 18, Que.

Combined Matron & Senior General Duty Nurse for hospital in Paper Mill Town in Province of Quebec. Day work only. To supervise general hospital operation & nursing staff of 9. Preferably bilingual. Approximate net salary after board deduction: $260 per mo. **Operating Room Nurse** for O.R. & Delivery Room Duty. Day work with occasional night emergency. Approx. salary after board deduction: $210. **X-Ray Technician** with training in any one of the following: General nursing, physiotherapy, clerical work, dietitian, pharmacy, laboratory technician. Salary after board deduction approx.: $210 per mo. or if also lab. technician: $235 per mo. Apply Personnel Manager, Quebec North Shore Paper Co., Baie Comeau, Que.

Technician (experienced) for Laboratory & X-Ray Dept. in new, fully equipped, active country hospital in connection with local clinic. Apply, giving details of training, experience, references, age & expected salary, Supt., Union Hospital, Langenburg, Sask.

Night Supervisor, General Duty Nurses, Registered & Grace Maternity Graduates. Apply, stating experience, Supt., Queens General Hospital, Liverpool, N.S.

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—Aluminium News

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